City of Port Colborne
Healthcare Advisory Committee Agenda

Date: March 23, 2026
Time: 6:00 pm
Location: Council Chambers, 3rd Floor, City Hall
66 Charlotte Street, Port Colborne

Pages

1. Call to Order

2. Adoption of the Agenda

3. Disclosures of Interest

4. Approval of the Minutes

   4.1 Healthcare Advisory Committee Meeting - March 9, 2026 — 1

5. Presentations

   5.1 Joanne Mataya - CEO of Community Living Port Colborne - Wainfleet — 4

6. New Business

   6.1 Review of Healthcare Community Engagement Plan for May - July — 10

   6.2 Correspondence from NOHT-Media Release March 6 2026 — 12

   New Niagara report identifies health system pressures, sets priorities for coordinated action

   6.3 NOHT Report: Planning for the Future-A Data-Informed Health System in Niagara — 14

   6.4 Meeting Dates

7. Adjournment

City of Port Colborne

Healthcare Advisory Committee Meeting Minutes

Date:	**Monday, March 9, 2026**
Time:	**6:00 pm**
Location:	**Council Chambers, 3rd Floor, City Hall** **66 Charlotte Street, Port Colborne**
Members Present:	C. Tamas M. Lallouet T. Triano S. McDowell, Chair P. McGarry, Vice-Chair R. Bodner, Councillor (non-voting) M. Aquilina, Councillor (non-voting)
Member(s) Absent:	W. Steele, Mayor (non-voting)
Staff Present:	J. Beaupre, Deputy Clerk B. Boles, Chief Administrative Officer G. Bisson, Senior Community Engagement Advisor E. Rzeczyca, Election Coordinator

1. Call to Order

The Chair called the meeting to order at 6:05 pm.

2. Adoption of the Agenda

Moved By M. Lallouet
Seconded By P. McGarry

That the Healthcare Advisory Committee Agenda, dated March 9, 2026, be approved.

Carried

3. Disclosures of Interest

There were no disclosures of interest.

4. Approval of the Minutes

4.1 Healthcare Advisory Committee Meeting - February 9, 2026

Moved By T. Triano
Seconded By P. McGarry

That the Healthcare Advisory Committee minutes, dated February 9, 2026, be approved.

Carried

5. Presentations

5.1 Ontario Long Term Care Association Presentation

Wiesia Kubicka, Vice-President of Policy and Communications for the Ontario Long Term Care Association presented to the Committee on Long Term Care in Ontario.

6. New Business

Renée Bisson, Senior Health Advisor, invited the Committee to the City's upcoming Open House events on Governance in Niagara on Thursday, March 12th, and Saturday, March 14th.

6.1 City of Port Colborne Healthcare Analysis Report prepared by KPMG

Renée Bisson, Senior Health Advisor, provided an overview of the Healthcare Analysis Report to the Committee.

6.2 Strategy Working Session

Renée Bisson, Senior Health Advisor, led the Committee through a Strategy Working Session based on the Healthcare Analysis Report.

Moved By M. Lallouet
Seconded By T. Triano

That the Committee move to endorse the Healthcare Analysis Report prepared by KPMG.

Carried

7. Adjournment

The Chair adjourned the meeting at 8:10 pm.

Sydney McDowell, Chair

Jessica Beaupre, Deputy Clerk

COMMUNITY LIVING
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In a community where everyone belongs

BARRIERS

Adult Community Support

At Community Living Port Colborne Wainfleet, we provide Adult Community Support services to approximately 80 adults Supported Independent Living, Community Participation Support (community navigation) and social/recreational Passport Programs.

Transportation for individuals in Port Colborne is a challenge. Businesses around the city often do not have functioning accessibility doors and ramps or ramps that are in good or safe condition.

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Access to Health Care for the individuals we serve is a challenge. With no Urgent care available after 8 PM, many of the persons supported do not have transportation to take them to the larger centers.

Many of our population also has a Dual Diagnosis (DD) and access to Mental health and addictions presents with long wait times for referral and assessment/treatment

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Suggestions to improve outcomes and services

Safety and security is often a challenge.

Another way to improve outcomes for those with IDD in relation to personal safety security include by holding fire safety courses, fire extinguishers training, seminars on appropriate internet safety, drug usage and sexual health. These are a few ideas as it is found there is a gap in education/knowledge.


Any
Questions

PORT COLBORNE

Community Engagement Plan for Healthcare

(May-July)

Purpose: Provide an overview of upcoming engagement activities that will support the development of the City's Community Health & Wellness Strategy from May 1 to July 1, 2026.

High-level engagement objectives:

- **Inform the community**: Ensure the community has clear, transparent, and accessible information on healthcare.
- **Gather feedback**: Provide residents with a wide range of in-person and virtual channels so they can freely share their feedback.
- **Promote inclusion:** Actively involve diverse community voices to facilitate conversations and representation.
- **Identify concerns and opportunities:** Review feedback to highlight areas of alignment and identify potential improvements.
- **Ensure transparency**: Provide the community with access to the feedback collected to help inform Council's decision-making.

The proposed engagement plan includes a variety of channels and mediums to ensure all key audiences are aware of the opportunity to provide feedback and can do so in a way that works best for them. This plan includes:

- **Online survey:** An online survey would launch on Friday May 1, 2026, and close on July 1, 2026, and would ask community members to offer their thoughts on the proposed plan.
- **Paper-based survey**: To accommodate community members who prefer an online survey, an identical paper-version would be available at various city facilities (City Hall, Vale Health & Wellness Centre, Port Colborne Public Library), local healthcare facilities, and other key locations throughout the community. The surveys would be collected for analysis after the last Open House on June 25, 2026.

- **In-person open houses / drop-in sessions:** City staff, City Council and members of the Healthcare Advisory Committee would host a series of in-person drop-in style open houses on May 20 and 21, and June 24 and 25.
- **Online Information Session(s)**: A virtual option will be available for those who can't attend the in-person open houses. Date and time to be confirmed.
- **Focus group session and/or interviews**: Will be scheduled with specific provincial priority populations (Seniors, youth, Indigenous, francophones etc.), committees of council, community organizations and healthcare providers/agencies throughout both months.

Communications Plan and Promotion

Successfully communicating about the engagement opportunities on healthcare will be a vital part of gathering meaningful feedback. The Corporate Communications team would launch a comprehensive communications campaign to help promote, which would include:

- Sharing information on the City's website on these pages:

  The Future of Healthcare in Port Colborne - City of Port Colborne

  Healthcare Advisory Committee - City of Port Colborne
- Radio interviews as part of the CKTB Round Table Road Trip on May 5.
- Posting social media content and the open house events on City channels
- Digital advertising opportunities
- Outreach to local media outlets to encourage coverage of the engagement opportunities
- Article in the May and June editions of City Hall News
- Postcards with a QR code delivered to each household
- Hard-copy posters with QR codes directed to the online survey shared in key community locations and with community special interest groups

For Immediate Release
March 06, 2026

New Niagara report identifies health system pressures, sets priorities for coordinated action

St. Catharines, ON – The Niagara Ontario Health Team – Équipe Santé Ontario Niagara (NOHT-ÉSON), together with regional partners, has released *Planning for the Future: A Data-Informed Health System in Niagara*—a comprehensive assessment of population health needs, service utilization, and system capacity designed to support coordinated, evidence-informed planning across the region with the goal of better-targeted care for Niagara residents.

The report establishes a baseline understanding of the region's population health, service utilization and available resources to guide collective planning and investment over the next five to 10 years. It also highlights the interconnected pressures affecting residents and health care practitioners across the region, including population growth and aging, rising chronic disease and multimorbidity, persistent primary care unattachment, increasing mental health and substance use needs, growing demand for EMS, ongoing hospital capacity pressures (including alternate level of care), workforce challenges across sectors, and the downstream health impacts of housing instability.

"The health system challenges in Niagara don't sit neatly in one place—pressures in housing, home and community care, and workforce capacity show up everywhere, including emergency departments and hospital beds," said Tara Galitz, Executive Director for the NOHT-ÉSON. "This report gives us a shared, Niagara-specific baseline so partners can align priorities and move forward together."

Rather than treating each challenge in isolation, the report emphasizes the need for cross-sector planning and shared solutions—linking primary care, public health, hospitals, community support services, long-term care and hospice, EMS, housing partners, and municipalities.

Planning for the Future outlines priority recommendations for system partners—ranging from expanding community-based chronic disease management and strengthening primary care navigation and attachment, to improving outbreak preparedness, embedding health equity tools and culturally appropriate navigation supports, scaling mobile integrated health approaches, addressing alternate level of care pressures by aligning post-acute capacity, strengthening supportive housing pathways, expanding long-term care and hospice capacity based on forecasting, and advancing data-driven workforce planning.

"Planning starts with evidence. By combining population health trends with service-use patterns, this assessment helps us anticipate Niagara's needs and will direct collaboration where it can

(Continued next page)

have the greatest impact on equity, access, and sustainability," said Dr. Darija Vujosevic, Clinical Lead for the NOHT-ÉSON and Vice Chair of the Niagara Practitioners' Healthcare Alliance.

The assessment was developed through collaborative efforts involving Brock University, Niagara College, Niagara Health, Niagara Health Knowledge Institute, and Niagara Region Public Health, and is intended to support system-level priority setting and ongoing monitoring as needs evolve.

"The *Planning for the Future* report gives us a clear, evidence-informed picture of the pressures affecting the health system in Niagara. It highlights where gaps exist today and where demand is growing, providing a strong foundation for planning and preparing for what's ahead," said Dr. Azim Kasmani, Medical Officer of Health at Niagara Region Public Health. "This is the first time we've collaborated on a report like this, and I'm proud of the collective effort behind it and the role it can play in supporting a healthier future for Niagara residents."

"Niagara College is pleased to partner in this project, which is a Niagara-wide approach to innovation," added Sinéad McElhone, Dean of Health Sciences at Niagara College. "Our joint achievement underscores Niagara College's commitment to academic excellence and our active participation in research that informs the future of healthcare management in Ontario."

-30-

The Niagara Ontario Health Team-Équipe Santé Ontario Niagara is a steadily growing network of nearly 50 health care providers, social service agencies, educational institutions, and patient/client and family/caregiver representatives. We are committed to working as one coordinated team to provide exceptional service, support, and care to you, no matter when or where you need it, now and for our future generations.

For interview requests or additional information, please contact:

Ron Laroche
Manager of Communications and Engagement
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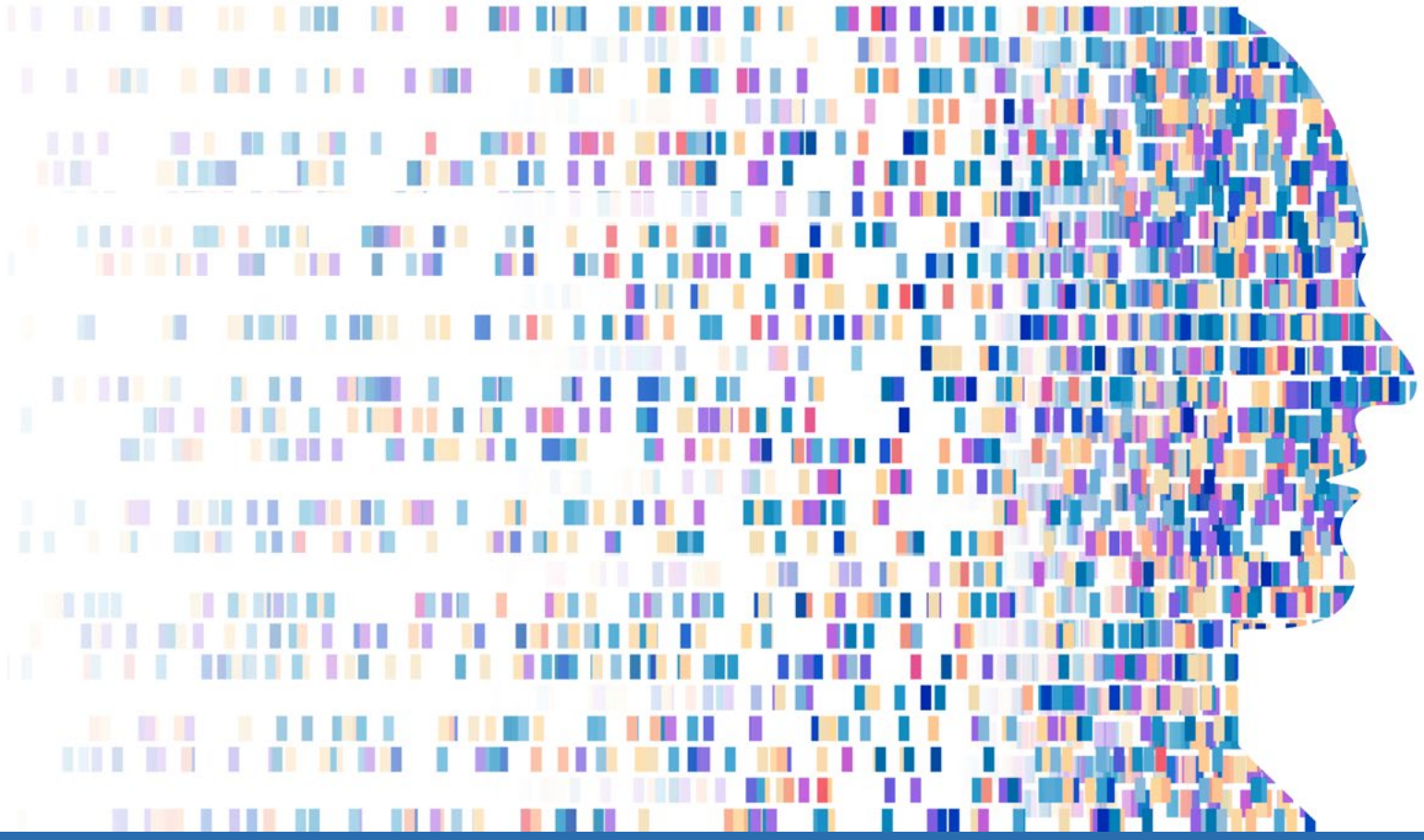
Mobile: 289-547-7046 | Email: communications@noht-eson.ca

PLANNING FOR THE FUTURE:

A DATA-INFORMED HEALTH SYSTEM IN NIAGARA



HEALTH SYSTEMS PLANNING REPORT FOR NIAGARA ONTARIO HEALTH TEAM – ÉQUIPE SANTÉ ONTARIO NIAGARA (NOHT-ÉSON)

Brock University

Niagara College Canada APPLIED DREAMS.

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Niagara Region

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INDIGENOUS LAND ACKNOWLEDGEMENT

We acknowledge that this work takes place on lands where Indigenous Peoples have lived for thousands of years, with their own unique cultures, identities, traditions, and languages. These lands are steeped in the rich history of First Nations such as the Hatiwendaronk, the Haudenosaunee, the Anishinaabe, and the Mississaugas of the Credit First Nation. There are many First Nations, Métis, and Inuit peoples from across Turtle Island who live and work in Niagara today.

We are committed to listening and learning from Indigenous Peoples and to acknowledging our responsibility to take meaningful action toward reconciliation within the healthcare system.

TABLE OF CONTENTS

EXECUTIVE SUMMARY

This report provides a comprehensive assessment of Niagara's health system capacity to inform co-ordinated, evidence-based planning led by the Niagara Ontario Health Team – Équipe Santé Ontario Niagara (NOHT-ÉSON). It establishes a baseline understanding of the region's population health, service utilization and available resources to guide collective planning and investment over the next five to 10 years.

This assessment was developed collaboratively by Brock University, Niagara College, the Niagara Health Knowledge Institute, Niagara Health and Niagara Region Public Health representing a collective effort to bring together data, research and system expertise across Niagara. Quantitative analyses were led by Niagara Region Public Health using existing data sources. The Niagara Health Knowledge Institute (NHKI) supported the conceptual framing through a rapid review of national and international literature on health system capacity. That companion report, *Defining Health System Capacity: A Rapid Review* (NHKI, 2025), informs the capacity definition and framework applied throughout this assessment.

The analysis uses the Canadian Institute for Health Information (CIHI) framework, **Stuff, Space, Staff and Systems**, to describe the material, physical, human and organizational components required to meet the health needs of Niagara's population. Capacity is examined across multiple parts of the continuum of care, including public health, primary care, emergency medical services, acute care, home and community care, long-term care, hospice and palliative care, mental health services and housing-related supports. Indicators and examples drawn from these areas highlight current system conditions and emerging pressures related to population aging, chronic disease, mental health and substance use, communicable disease activity, homelessness and workforce sustainability.

This report is descriptive in nature and synthesizes readily available data to identify patterns, pressures and gaps relevant to system planning. While trends and projections are presented where available, no formal analysis was conducted to assess causal relationships between population characteristics, service utilization and system capacity. This report is intended to inform the current situation, which can inform future complex analyses.

CIHI CAPACITY COMPONENTS ACROSS THE CONTINUUM OF CARE

SECTOR	STUFF MATERIAL RESOURCES	SPACE INFRASTRUCTURE	STAFF WORKFORCE	SYSTEM
Public Health	Preventative and protective health interventions (such as immunization delivery, screening services, dental care programs, harm-reduction supplies, and maternal health and early years supports)	Community based, school based and mobile service delivery; clinics and outreach settings	Health Promoters, Public Health Nurses, Public Health Inspectors, Outreach staff, Registered Dental Hygienists	Surveillance systems, public health Electronic Medical Records, population health information systems
Primary Care	Clinics, Community Health Centres	Distribution of primary care sites	Family Physicians, Nurse Practitioners	Electronic Medical Records, virtual care, referral pathways
Acute Care (Hospitals)	Beds, diagnostics and specialized equipment	Hospital sites and service configuration	Nurses, Physicians and Allied Health Professionals	Health Information System, clinical workflows, service coordination
Home and Community Care	Home care supports and supplies	Care delivered in home and community settings	Personal Support Workers, nurses, interdisciplinary teams	Care coordination systems
Long-term Care and Hospice	Long-term care beds, hospice and palliative resources	Residential and long-term care homes	Nursing and Personal Support Workers, interdisciplinary teams	Transitions to care, discharge planning, placement coordination
Mental Health Services	Crisis supports, treatment and recovery programs	Community and inpatient mental health settings	Mental health and addictions workforce	Integrated mental health, crisis response and referral pathways
Housing-Related Supports	Shelter beds, supportive housing units	Emergency shelters and supportive housing locations	Intake staff and case managers	Coordinated access, housing navigation and referral systems

KEY FINDINGS

- Population aging and growth are increasing demand for all health services
- Chronic disease prevalence and multimorbidity are rising, contributing to increased complexity of care and increased demand for health services
- Primary care unattachment remains a large challenge, limiting prevention and early intervention and increasing reliance on emergency services
- Mental health and substance use needs continue to drive emergency department utilization among populations facing housing and socioeconomic instability
- Emergency Medical Services (EMS) demand is increasing and is forecasted to continue rising, with implications for response performance and emergency preparedness
- Hospital capacity pressures persist, driven by rising acuity, Alternate Level of Care (ALC) days, diagnostic demand, and care needs among individuals experiencing homelessness
- Workforce pressures span multiple sectors, including primary care, hospitals, EMS, long-term care, hospice, and community services
- Housing instability and limited supportive housing capacity contribute to preventable health deterioration and downstream system pressures

IMPLICATIONS FOR SYSTEM CAPACITY

Taken together, these findings demonstrate that capacity pressures in Niagara are interconnected across sectors. Constraints in community, long-term care, hospice, workforce, and housing capacity directly affect emergency and hospital services. Addressing system performance therefore requires coordinated, cross-sector planning rather than isolated interventions within individual services.

NEXT STEPS

This assessment establishes a regional baseline from which NOHT-ÉSON and system partners can prioritize system-capacity investments, guide coordinated planning across sectors and inform subsequent engagement to align planning and implementation efforts. This assessment is intended to support collective decision-making and future forecasting as partners work together to respond to emerging pressures and evolving population needs.

INTRODUCTION

OVERVIEW

The capacity of a health system to deliver services should be informed by the health of the population, demographic change, and evolving public health challenges. A resilient and responsive health system must have the necessary infrastructure, workforce, data systems, and coordination to deliver timely, high-quality, and equitable care. Understanding existing strengths and identifying areas of vulnerability are essential to ensure the system can continue to meet the needs of Niagara's population now and into the future.

This report presents a comprehensive assessment of health system capacity in Niagara to inform coordinated, evidence-based planning led by the Niagara Ontario Health Team – Équipe Santé Ontario Niagara (NOHT-ÉSON). The assessment describes the current state of population health needs, health system resources and service utilization across the region, establishing a baseline from which to identify priorities for system improvement and investment over the next five to 10 years.

ASSESSMENT APPROACH

The analysis draws on existing data sources and compiles evidence through collaborate efforts of Brock University, Niagara College, Niagara Health, Niagara Health Knowledge Institute (NHKI), and Niagara Region Public Health (NRPH). NRPH led the quantitative and descriptive analyses, while NHKI conducted a rapid review of health system capacity frameworks to identify a standardized conceptual foundation for this assessment. Supported by the findings of the NHKI rapid review, the project team adopted the Canadian Institute for Health Information (CIHI) definition of health system capacity. This framework provides the foundation for interpreting findings throughout the report. Each subsequent section of the current state assessment, including Demographics, Population Health, and System Resources and Utilization is organized to reflect these four interrelated dimensions, offering an integrated understanding of Niagara's health-system capacity and the factors that influence its sustainability over time.

This report directly supports the NOHT-ÉSON 2024–27 Strategic Plan, including priorities related to:

- Access to primary care
- Integrated and coordinated care
- Equity and inclusion
- Workforce sustainability
- System trust and accountability

HEALTH SYSTEM CAPACITY

A clear and standardized definition of health system capacity is essential to support consistent interpretation and planning. Within this report, health system capacity is defined to align with the Canadian Institute for Health Information (CIHI) framework[1], which provides an operational model for assessing the resources and structures required to deliver health services.

Health system capacity is the adequate number of supplies and equipment ("Stuff"), space and structure in which to treat patients ("Space"), trained personnel ("Staff"), and policies and procedures ("Systems") to meet the health-care needs of the population.

This definition, adopted as the official framework for the NOHT-ÉSON System Planning Report, was selected following a rapid review of academic and grey literature conducted by the NHKI. The review identified substantial variation in how capacity is described across sources. However, it identified the CIHI definition as a pragmatic and comprehensive approach to guide system-level assessment.

The NHKI rapid review demonstrated that the CIHI framework aligns with broader conceptualizations of capacity identified internationally, including dimensions such as governance, preparedness, data and information systems, financing and trust. These elements reinforce the interdependence of physical resources, and workforce and system structures in determining a region's ability to deliver timely, high-quality and equitable care.

By grounding this report in the CIHI framework and current evidence base, the analysis provides a comprehensive foundation for describing Niagara's health system capacity and establishing a baseline to inform future planning and co-ordination led by the NOHT-ÉSON.

[1] Canadian Institute for Health Information. Health System Capacity: Measures to Support System-Level Monitoring in Canada. CIHI; 2022.

CURRENT STATE

ASSESSMENT

Health and well-being in Niagara are influenced by a range of factors, including the social and economic conditions in which people live, their access to care, and the changing characteristics of the population. This section provides a current state assessment of the health system in Niagara, summarizing the key indicators, emerging challenges, and opportunities that shape population health and service demand. The analysis is descriptive rather than evaluative and is presented from a health system capacity lens, illustrating how demographic, health, and resource conditions influence the region's ability to meet current and future needs.

The current state assessment offers comprehensive insights across key areas:

1. Demographics
2. Population Health
3. System Resources and Healthcare Utilization

Where possible, each section considers forecasting and/or projections to support planning.

EQUITY CONSIDERATIONS

Health equity is an important consideration in understanding Niagara's population health and system capacity. While available indicators, such as the Ontario Marginalization Index (ON-Marg), provide some insight into how social and economic conditions influence health outcomes and service use, comprehensive sociodemographic data are not yet routinely or systematically collected across the health system.

As a result, this assessment incorporates equity considerations where data permit, using population and area-level information to highlight where disparities are likely to exist. However, the absence of consistent, person-level sociodemographic information, such as race, ethnicity, income, language, and disability limit the ability to quantify inequities or assess their impact on system capacity.

This limitation underscores the need for a coordinated regional approach to sociodemographic data collection that is standardized, community-informed, and aligned with provincial guidance. Establishing this foundation would enable future planning to more accurately identify disparities, monitor progress toward equity, and ensure that system-capacity improvements benefit all residents across Niagara.

1 DEMOGRAPHICS

To understand the demographic makeup of Niagara, the Census Profile from Statistics Canada is used, unless otherwise shown. Information on the Census is collected every five years with 2021 being the most recent collection year.

THE NIAGARA CONTEXT

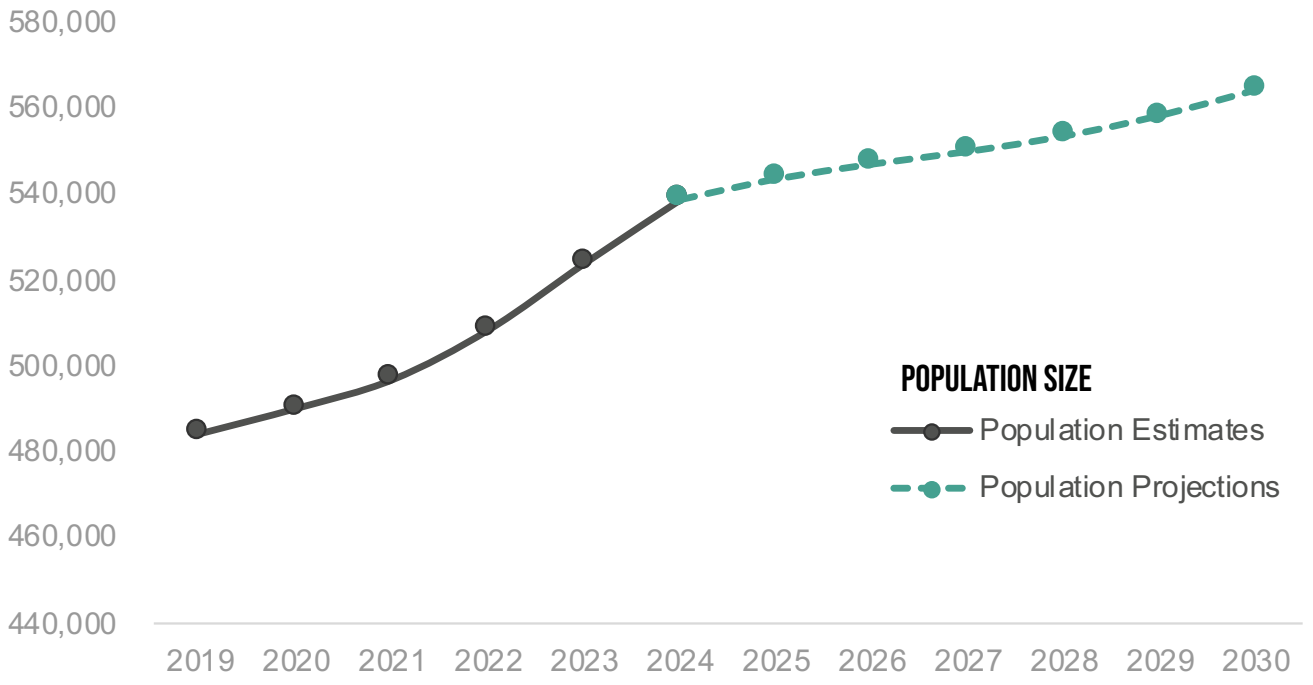
The region of Niagara is comprised of 12 municipalities and is located between Lake Ontario and Lake Erie in southern Ontario covering 1,852 square kilometers. The population size of Niagara increased 6.7 per cent since the last Census.[2] The region is a mix of three urban centres, large areas of agricultural/rural land and several small townships with mixed levels of growth and industry. The largest populated municipalities in Niagara are St. Catharines, Niagara Falls and Welland. The least populated municipality is Wainfleet. Agriculture is a large economic driver for the region and generates a unique population to serve in the International Agricultural Workers (approximately 3,755 each year[3]) who staff farms and vineyards across the region. In Niagara, the majority of Temporary Foreign Workers originate from the Caribbean and Mexico.

[2] Statistics Canada, 2016 Census of the Population

[3] Municipality and occupancy breakdown, July 2019. Note. For additional information on local temporary foreign workers, refer to: Niagara Priority Profiles on Ethno Racial and Immigration

WHAT ARE THE PREDICTED TRENDS IN THE POPULATION?

Population projections show Niagara will continue to see a steady increase in its population



Data Source: Statistics Canada, 2024; Ontario Ministry of Finance, 2025

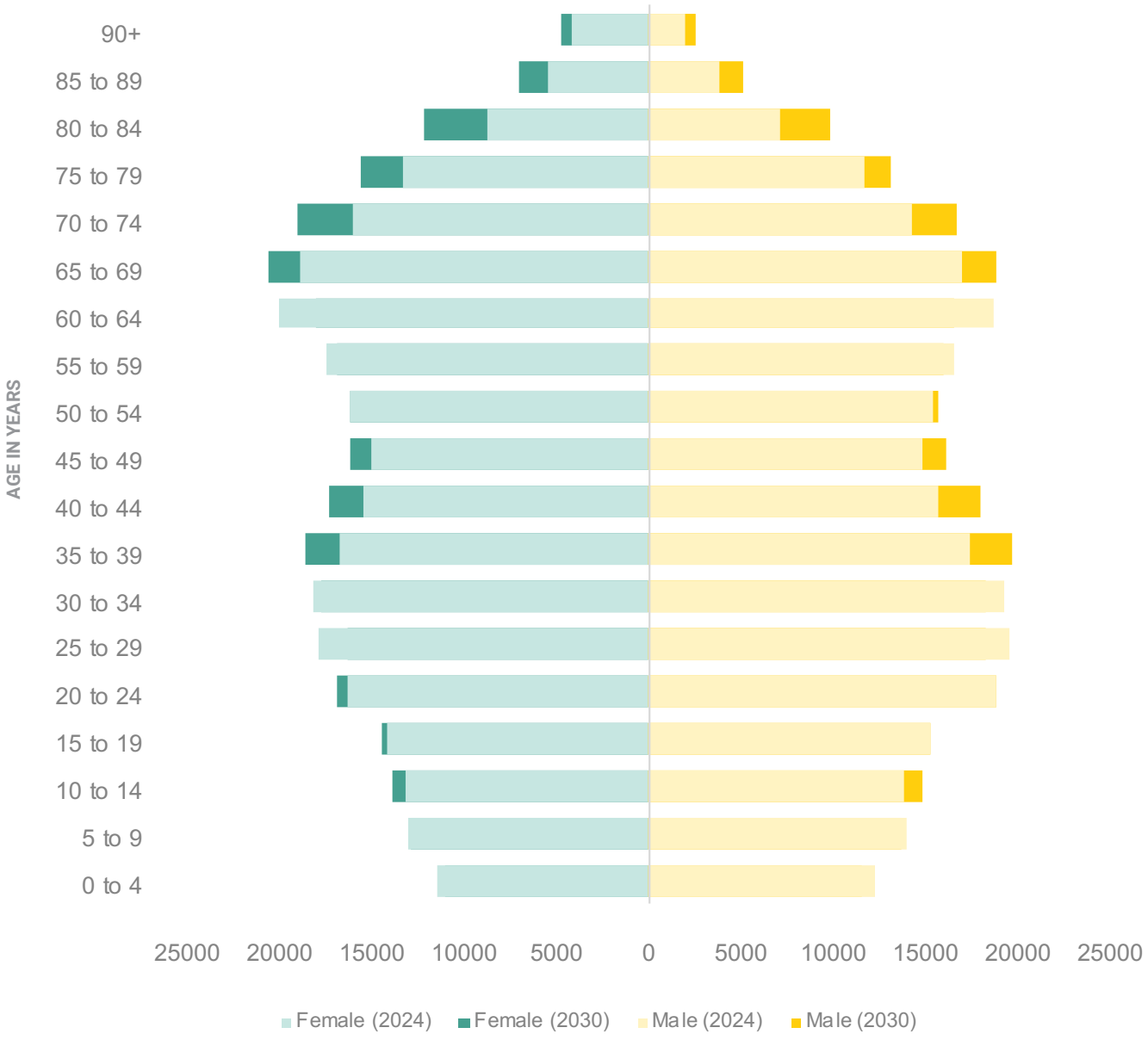
KEY OBSERVATIONS

From 2023 to 2024, the population size of Niagara increased by 2.8 per cent or 14,879 individuals; Niagara Falls experienced the largest population increase of 6.2 per cent or 6,512 individuals whereas West Lincoln experienced a population decrease of 0.5 per cent or 83 individuals.

Niagara's population projection rates through 2030 are consistent with the province's rate. Population projections indicate that Niagara will continue to see a steady increase in its population from 484,571 in 2019 to 564,639 in 2030.

WHAT IS THE AGE STRUCTURE OF THE POPULATION?

The age pyramid for Niagara's population below shows the population is aging and there are fewer births expected.



Data Source: Ontario Ministry of Finance, 2025

KEY OBSERVATIONS

By 2030, Niagara's population will become older as those 65 years old or older will make up approximately 25.8 per cent of the population. The 2024 estimates suggest that 65 years or older years old currently make up approximately 22.7 per cent of the population; this is an increase of 3.1 per cent or 23,128 individuals.

Given declining birth rates and the projected concentration of growth among adults aged 65 and older, population growth in Niagara appears to be driven largely by people moving into the region rather than natural increase. Available projections reveal that many of these in-migrants are older adults relocating to Niagara, which contributes to the region's older age structure.

WHAT WILL BE THE CHANGE IN POPULATION SIZE BY AGE GROUP?

Niagara's net change in population between 2024 and 2030 shows that more than 90 per cent of projected population growth will occur among adults 65 and older.

Net change in population, where the negative axis represents a decrease, and the positive axis represents an increase in the population

Data Source: Ontario Ministry of Finance, 2025

KEY OBSERVATIONS

By 2030, the population is projected to be 54.5 per cent female and 45.5 per cent male; this is slightly different from 2024 estimates that show 50.4 per cent of the population is female.

SO WHAT?

Niagara's age structure is shifting toward older populations, with most growth occurring among adults 65 years and older. Understanding this pattern is important because different age groups tend to have different types of health needs. The demographic shift toward an aging population provides essential context for interpreting the health conditions and patterns of service use discussed in the Population Health and Service Utilization sections that follow.

ADDITIONAL DEMOGRAPHIC INFORMATION ABOUT THE POPULATION OF NIAGARA

FAMILY INCOME

$86,000

Niagara after tax median family income

$62,000

Niagara single parent after tax median income

21.4%

Niagara families spend 30 per cent or more of their income on housing

Note:
The 30% housing cost guideline suggests that total monthly housing expenses should not exceed 30% of an individual's gross income. This benchmark is commonly used in financial planning and housing policy to assess affordability and identify potential cost burdens

Niagara has a higher concentration of middle- and lower-income residents, with fewer individuals in high-income brackets compared to the rest of Ontario.

MARITAL STATUS OF THE POPULATION OF NIAGARA VERSUS ONTARIO

In Niagara, 56.8 per cent of individuals (15+ years) are married or in a common-law relationship; this is the most reported marital status. Twenty-six per cent of Niagara residents report being single, which is lower compared to the population of Ontario (29.4 per cent).

ONTARIO MARGINALIZATION (ON-MARG) INDEX

ON-Marg is a tool that helps identify which communities in Ontario face greater social and economic challenges. The index examines factors such as income, housing, employment, and diversity to highlight areas where people may be experiencing more difficulties. Breaking down these factors provides a clearer picture of where support is most needed, helping make services fairer and more accessible across the province.

Neighbourhoods with the highest marginalization include:

- St. Catharines: Western Hill, Queenston and Facer/Cushman
- Niagara Falls: Elgin and Drummond/Victoria
- Welland: Eastdale/Cordage and Crowland/Welland South
- Fort Erie: Fort Erie North

Neighbourhoods with higher concentrations of newcomers and racialized populations include:

- St. Catharines: Western Hill, Queenston and Facer/Cushman
- Niagara Falls: Beaverdams, Westlane, Drummond/Victoria and Elgin
- Thorold: St. John's/Port Robinson/Allanburg

This neighbourhood-level information provides important context for understanding variation in demographic composition across the region. When considering site selection to offer specific services, these can be used as a reference to determine where the most at-risk are located and address equity concerns related to healthcare access.

Note:
See maps in Appendix B.

PRIMARY LANGUAGE SPOKEN AT HOME

91.0 per cent of residents in Niagara primarily speak English at home, a higher percentage compared to the population of Ontario (77.4 per cent).

- 0.6 per cent of residents in Niagara primarily speak French at home, a lower percentage compared to the population of Ontario (1.8 per cent). Under one per cent of Niagara residents speak both English and French, this is similar to the population of Ontario (0.7 per cent).
- While the proportion of residents who primarily speak French at home is small overall, French-speaking populations are more concentrated in specific areas- particularly in Welland and surrounding communities.

There is a lower percentage of Niagara residents who primarily speak an unofficial language at home (6.3 per cent) compared to the population of Ontario (15.7 per cent).

- Among residents whose primary home language is none of the official languages, the most reported languages include Spanish, Mandarin and Italian.
- Although English remains the predominant language across the region, linguistic diversity varies by neighbourhood. This can reflect settlement patterns in communities with higher proportions of newcomers and racialized residents, which aligns with visible minority distributions described below.

IMMIGRATION

There is a lower per cent of Niagara residents who are non-Canadian born (19.5 per cent) compared to the population of Ontario (33.3 per cent).

VISIBLE MINORITY

The most common visible minorities in Niagara are South Asian (22.2 per cent), Black (21.3 per cent) and Latin American (11.2 per cent).

SO WHAT?

Niagara's socioeconomic and diversity patterns highlight important variations across communities that shape the context in which residents live and access services. Differences in income levels, housing affordability, marital status, levels of marginalization, linguistic diversity, newcomer status and visible minority distribution point to a population that is not uniform across the region. These characteristics do not indicate needs on their own but help to identify where demographic conditions may influence patterns of health, wellbeing, and service use, which are explored in the sections that follow.

INDIGENOUS IDENTITY OF NIAGARA RESIDENTS[4]

Data describing Indigenous identity requires a different interpretive approach than other demographic variables. Indigenous data are shaped by the ongoing impacts of colonization, including forced displacement, residential schools, discriminatory legislation, and longstanding mistrust of government-led data collection. As a result, national Census counts tend to under capture Indigenous populations.

These factors—combined with the rights affirmed by OCAP® (Ownership, Control, Access, and Possession)[5]—mean that Census statistics should be interpreted with caution. They provide only a partial picture of Indigenous presence in the region and should not be used to draw conclusions about health needs, wellbeing, or service utilization. Indigenous communities and organizations remain the primary stewards of Indigenous data and the appropriate sources for contextualized interpretation.

[4] According to Statistics Canada, Indigenous identity refers to whether a person identifies with the Indigenous Peoples of Canada, including "First Nations (North American Indian), Metis or Inuk (Inuit) and/or those who are Registered or Treaty Indians (registered under the Indian Act of Canada) and/or those who have membership in a First Nation or Indian Band.

[5] OCAP® is a registered trademark of the First Nations Information Governance Centre (FNIGC), www.fnigc.ca/ocap-training

ESTIMATED PROPORTION OF POPULATION IN NIAGARA IDENTIFYING AS INDIGENOUS

13,960 or three per cent of individuals in Niagara identify as Indigenous, similar to Ontario

Among those who identify as Indigenous in Niagara, 55.8 per cent identify as First Nations. There is a higher percentage of individuals identifying as Metis in Niagara (38.6 per cent) compared to Ontario (33.1 per cent).

Urban Indigenous community organizations provide culturally appropriate services to support Indigenous residents living in Niagara. Today, people living in urban settings make up most of the Indigenous population.

GEOGRAPHICAL VARIATION

The municipality with the highest proportion of Indigenous peoples is Port Colborne (5.4 per cent), followed by Fort Erie (5.0 per cent) and Welland (4.3 per cent).

EDUCATION

Among those who are Indigenous, 10.0 per cent report obtaining a bachelor's degree or higher. This is lower compared to 20.5 per cent of non-Indigenous Niagara residents.

Over 22 per cent of Indigenous individuals report having no certificate, diploma or degree. This is higher compared to 15.2 per cent of non-Indigenous Niagara residents.

	Niagara		Ontario	
	Number of People identifying as Indigenous	Per cent of total population identifying as Indigenous	Number of People identifying as Indigenous	Per cent of total population identifying as Indigenous
First Nations	7,785	55.8%	251,030	61.7%
Métis	5,390	38.6%	134,615	33.1%
Indigenous responses not included elsewhere	415	3.0%	9,515	2.3%
Multiple Indigenous responses	220	1.6%	7,115	1.7%
Inuk (Inuit)	150	1.1%	4,310	1.1%

Note:
Interpret the results with caution. According to Statistics Canada, these estimates are more affected than most by the incomplete enumeration of certain First Nations reserves and settlements. In addition, Indigenous individuals may be less likely to participate in the survey due to limited trust in government. These patterns are also shaped by the ongoing impacts of colonization, which have contributed to systemic barriers, historical trauma, and reduced engagement with government institutions.

Data Source:
Statistics Canada Census, 2021

EMPLOYMENT

Among those who are Indigenous, 79.6 per cent are employed. This is lower compared to 84.6 per cent of non-Indigenous Niagara residents.[6]

INCOME

Among those who are Indigenous, 15.3 per cent are considered low income based on the low-income measure (after tax). This is higher compared to 10.3 per cent of non-Indigenous Niagara residents.[7]

[6] Employment is calculated by dividing the total number of employed individuals by the total number of individuals participating in the labour force.

[7] The Low-income Measure (LIM) is a relative poverty line set at 50% of the median household income, adjusted for household size. Households below this threshold are considered to have significantly fewer resources than the average family.

IMPORTANT

Please refer to the Indigenous Niagara Priority Profile for further information covering Indigenous data use, local qualitative data, OCAP principles, and considerations for planning, particularly from the Creating Our Way Forward Report which aims to address important health issues and concerns within the Niagara region for the Indigenous population.

2 POPULATION HEALTH

This section provides data to understand the health of the Niagara population. It includes information on health risk and protective factors, maternal and child health, cancer incidence and mortality, chronic disease prevalence, and infectious and communicable disease prevalence. It also highlights persistent and emerging health issues affecting health system capacity.

RISK AND PROTECTIVE FACTORS FOR HEALTH

Several risk and protective factors underlie health and contribute to chronic disease. This section of the report examines risk and protective factors for health such as overall general health status, perceived mental health status, sense of belonging to the community status, cannabis use, screentime and sedentary behaviours.

PERCEIVED WELL-BEING AND COMMUNITY BELONGING (12+ YEARS)

57.6%
Perceived general health, very good or excellent

71.0%
Somewhat or very strong community belonging

56.9%
Perceived mental health, very good or excellent

Data Source:
Canadian Community Health Survey, 2021/2022

There are no significant differences observed by age.

SMOKING, ALCOHOL AND CANNABIS

Data Source:
Canadian Community Health Survey, 2021/2022

Note:
Heavy drinking refers to males who reported having five or more drinks, or women who reported having four or more drinks, on one occasion, at least once a month in the past year.

15.8%

Current, daily or occasional smoker

34.2%

Heavy "binge" drinkers

21.3%

Used cannabis at least once in past 12 months

There are significantly more current, daily or occasional smokers between 50-64 years old compared to those who are 18-34 years old and 65 years and older.

42 per cent for males and 26.7 per cent for females.

FRUIT AND VEGETABLE CONSUMPTION

Note:
Sugar-sweetened beverages include: a can, bottle or glass of pop (such as regular Coke, Pepsi, Sprite), sports drinks (such as Gatorade), fruit cocktails, lemonades, pre-sweetened tea or coffee (such as Iced Tea or Frappuccino), bubble tea, and chocolate milk. It does not include, diet pop, G2, 100% fruit juice or plain water.

17.1%*

Consume fruits and vegetables five or more times per day (18+ years)

14.3%

Students in grades seven and eight consumed sugar-sweetened beverages least five times in the last 7 days

23.0%

Students in grades nine to 12 consumed sugar-sweetened beverages at least five times in the last seven days

* Interpret with caution due to high sampling variability

Data Source:
Canadian Community Health Survey, 2021;
Ontario Student Drug Use and Health Survey, 2019

PHYSICAL ACTIVITY AND SCREEN TIME

Data Source:
Canadian Community Health Survey, 2021

Note:
A person has met their physical activity recommendations if, in the last seven days, adults aged 18 and older have accumulated at least 150 minutes of moderate to vigorous aerobic physical activity.

45.9%

Meeting or being above physical activity guidelines* (18+ years)

68.0%

More than two hours of screentime on school/ workday in the past seven days (12+ years)

83.4%

More than two hours of screentime on non-school/ workday in the past seven days (12+ years)

There is a significantly higher percentage of those between the ages of 18 to 34 years who have more than two hours of screentime on non-workdays than those between the ages of 35 to 44 years and 45 to 64 years.

SO WHAT?

Addressing modifiable risk factors such as excessive alcohol use, unhealthy diet, tobacco use, and physical inactivity are essential because these behaviours significantly contribute to the development and progression of chronic diseases. By targeting these factors through prevention and health promotion strategies, health systems can reduce disease burden, improve quality of life, and lower healthcare costs. A focus on these risks will offer the greatest potential for long-term population health improvement.

CHILD AND MATERNAL HEALTH

A child's healthy development begins with a pregnant individual's health. A healthy start during pregnancy influences infancy, childhood and adulthood. Many factors can affect pregnancy and childbirth, including age, weight, access to healthcare, and exposure to substances. Other factors such as education, family income, breastfeeding and the mental health of parents and caregivers also impact infant and child health.

MATERNAL AND NEWBORN HEALTH BY THE NUMBERS

Notes:

1. The denominator includes the total number of individuals who gave birth and not the number of live births.
2. The denominator is the number of live births minus any missing data. There are substantial amounts of missing data; as such, results should be interpreted with caution;
3. The denominator is the number of live births and excludes missing data.

Data Source:
Better Outcomes and Registry Network, 2024; IntelliHealth, 2024

7.3%

Crude birth rate per 1,000 population

35.2%

Niagara pregnant individuals who gave birth took folic acid prior to and during pregnancy

4.5%

Niagara pregnant individuals were exposed to cannabis during pregnancy

40%

Individuals gave birth between 30 and 34 years of age[1]

12.8%

Niagara pregnant individuals who gave birth report a mental health concern during pregnancy (such as anxiety, depression, history of postpartum depression, addiction, bipolar disorder, schizophrenia)

1.7%

The percentage of individuals with alcohol exposure in pregnancy

44.9%

Individuals exclusively breastfeed at hospital discharge[2]

7%

Low birth weight rate per 100 live births[3]

1%

Niagara individuals used alcohol, illicit drugs or prescription and non-prescription drugs inappropriately during pregnancy

SO WHAT?

Early childhood indicators show that nearly one in five children are vulnerable in physical health and well-being. Healthy development begins before birth and continues through the earliest years of life, shaping the trajectory for health, learning, and well-being into adulthood. When early health is compromised, the risks of chronic disease, mental health needs, and greater health system utilization increase across the lifespan.

CANCER STATISTICS FOR NIAGARA

INCIDENCE AND MORTALITY

[8] Ontario Health (Cancer Care Ontario). Ontario Cancer Statistics 2024. Toronto: Ontario Health, 2024

Cancer is a leading cause of death in Ontario.[8] In addition to the large impact on mortality, many cancer diagnoses can be prevented with lifestyle and policy changes.

The Ontario Cancer Registry is used to track cancer incidence and mortality. It passively collects data from hospital records, regional cancer centres, pathology reports, and death certificates. Niagara belongs to the Hamilton Niagara Haldimand Brant Regional Cancer Program, with Juravinski Cancer Centre as the regional hub. The registry is dynamic, allowing new cases and updates to be added over time. For reporting, incident cases are classified by site of origin using ICD-O-3 topography codes, grouped into cancer types defined by Ontario Health. Deaths are classified using ICD-10 coding rules.

NUMBER OF NEW CASES

Data Source:
Ontario Cancer Registry
SEER*Stat Package - Release 12
(March 2021).

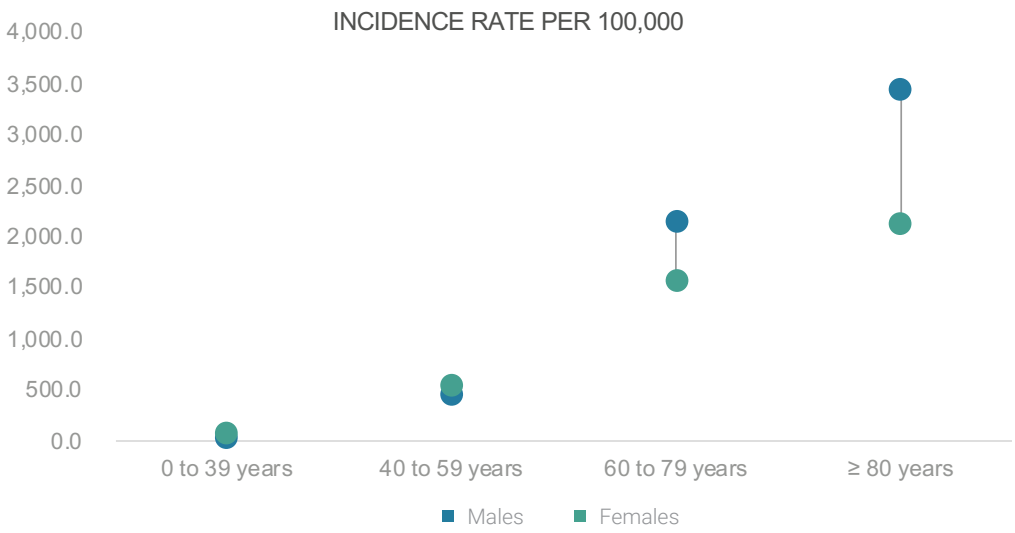
3,547

new cases of all cancers were diagnosed in 2018

- The incidence rate of new cancer diagnosed in Niagara is higher than the provincial rate; Specifically, the incidence rate of lung cancer, myeloma and leukemia is higher in Niagara compared to Ontario. The incidence rate for myeloma is the second highest across all Public Health Units and the incidence rate for leukemia is the fourth highest out of all Public Health Units. Even though the incidence rate of non-Hodgkin's lymphoma is not significantly different in Niagara compared to the province, the rate in Niagara is the fifth highest across all regions.
- The incidence rate of thyroid cancer is lower in Niagara compared to the provincial rate.
- Overall, lung, breast and prostate cancer make up the majority of cancers diagnosed in Niagara residents. Prostate cancer is the most commonly diagnosed cancer among males, accounting for 23.3 per cent of all new cancer cases in 2018. Among females, breast cancer is the most commonly diagnosed cancer accounting for 25.4 per cent of all new cancers. For both sexes, lung cancer is the second most common cancer diagnosed followed by colorectal cancer.
- Since 2010, the incidence of new cancers in Niagara is significantly declining. This is explained by the significant decline in incidence cases among males over time as the incidence of new cancers among females is still stable.
- The top five cancers diagnosed in 2020 are: lung, breast, colorectal, prostate and melanoma (Cancer Care Ontario, 2024).

Cancer incidence increases with age and affects more **males** than **females** over the age of 60 years in Niagara.

Data Source:
Ontario Cancer Registry
SEER*Stat Package - Release 12 (March 2021).



NUMBER OF CANCER DEATHS

1,341

residents died from cancer in 2018

Data Source:
Ontario Cancer Registry
SEER*Stat Package - Release 12 (March 2021).

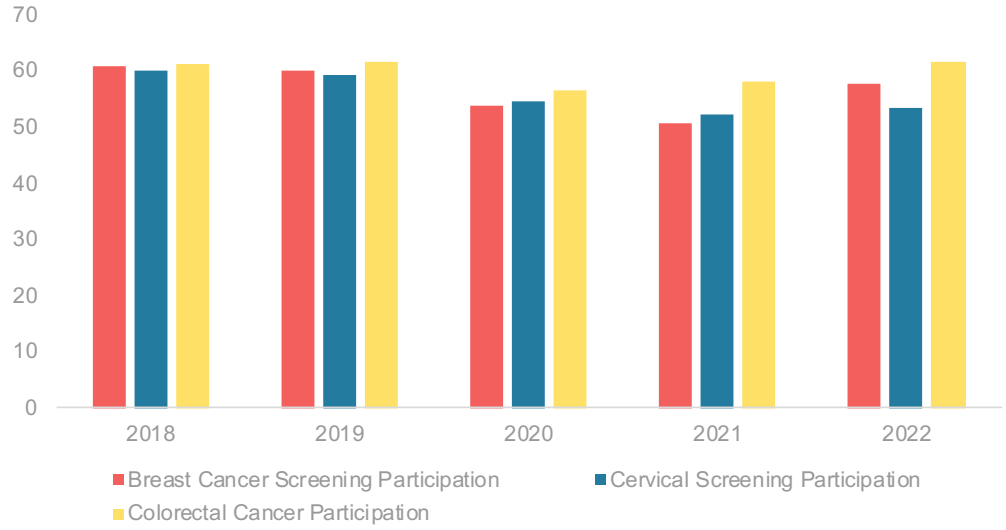
- The overall mortality rate for all cancers, adjusted for age is 205.0 per 100,000 for Niagara which is higher than the Ontario rate of 184.5 per 100,000
- The mortality rate specifically for lung cancer is also higher in Niagara compared to the province (52.1 per 100,000 versus 46.7 per 100,000)
- Even though males of all ages are most commonly diagnosed with prostate cancer, the majority of cancer deaths among males are from lung cancer. Even though females are most commonly diagnosed with breast cancer, the majority of cancer deaths are from lung cancer. This may speak to the improvements in screening and diagnosis for prostate and breast cancer and the effectiveness of treatment options available.
- Mortality rates in 2018 by age and sex also show similar patterns to incidence (not shown). Mortality rate increases as age increases but more drastically for residents over the age of 80 years. The mortality rate is greater for males at older ages compared to females.
- Since 2010, the mortality rate from all cancers has not significantly changed over time but is still significantly higher for males compared to females.
- In 2020, the top five cancers Niagara residents died from were: lung, colorectal, pancreas, breast and prostate.

CANCER SCREENING

Data Source:
Ontario Health (Cancer Care Ontario), Cancer Screening, QM Analytics (Updated June 2024)

Cancer screening is an important preventive approach to ensure early detection and better long-term outcomes. Local participation in breast cancer, cervical cancer and colorectal cancer screening programs declined from 2018 to 2020, likely due to the impact of the COVID-19 pandemic. This decline is also seen across the province. As of 2022, screening participation may be starting to increase back to pre-pandemic levels.

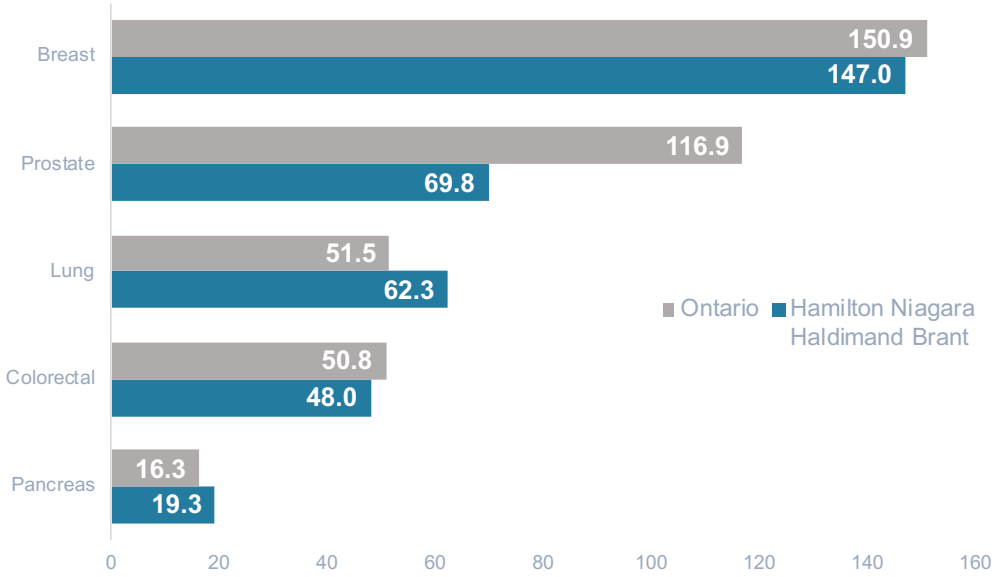
Per cent Cancer Screening Participation among those Eligible in Niagara



CANCER PROJECTIONS

Data Source:
Ontario Health (Cancer Care Ontario), Cancer Screening, QM Analytics (Updated June 2023)

Note:
Visual presents rates per 100,000 population



Compared to Ontario, Hamilton Niagara Haldimand Brant region (HNHB) could have significantly lower rates of prostate cancer by 2030; however, HNHB could have significantly higher rates of pancreatic and lung cancer. Rates of breast and colorectal cancer could remain at levels like Ontario.

- Cancer data indicates that projections will remain stable. The Hamilton Niagara Haldimand Brant (HNHB) region is expected to experience between 533.6 and 535.6 cases per 100,000 population from 2026 to 2030.
- HNHB is projected to have significantly lower cases of cancer compared to the province. By 2030, it is projected that HNHB could have 12,350 or 533.6 per 100,000 cases of cancer compared to 558.5 per 100,000 in Ontario.
- Compared to other regions, HNHB would be in the second-lowest quintile compared to other sub-regions in Ontario.

SO WHAT?

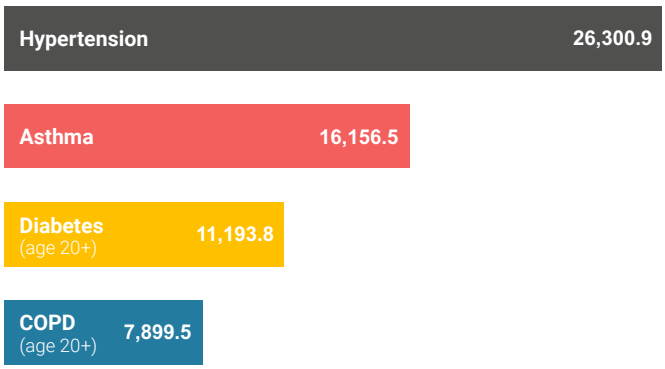
Since 2018, the healthcare system has faced strain from the COVID-19 pandemic, which has disrupted local cancer trends. Routine cancer screenings in Niagara declined, and IC/ES data show a 34.3 per cent drop in diagnoses after the first lockdown in March 2020. Surgery cancellations and delays further increased risks of late-stage detection and poorer outcomes.[9,10] Researchers estimate many cancers remain undetected, with long-term survival likely affected, though full impacts will only be understood through ongoing monitoring by IC/ES, Ontario Health, and Public Health. Data as of 2022 suggests that screening participation may be starting to increase back to pre-pandemic levels although additional data is needed. Projections remain stable and significantly lower than Ontario, with breast cancer likely being the most dominant. Priority should be placed on early screening and diagnosis where possible.

OTHER CHRONIC DISEASES

Chronic diseases account for most of the morbidity, mortality and healthcare utilization across Niagara and Ontario as a whole.[11] Conditions such as cardiovascular disease and diabetes are influenced by a range of factors such as age, lifestyle behaviours and social determinants of health. Despite advances in treatment and management, disparities persist, especially among populations facing socioeconomic challenges.

Measuring the prevalence of chronic diseases is challenging due to factors such as underdiagnosis, inconsistent reporting, and variations in population health data sources. Many individuals with chronic conditions may remain undetected because symptoms can be mild or attributed to other causes, and self-reported data often lacks accuracy.

Prevalence of Chronic Conditions in Niagara (per 100,000)



Data Source:
Public Health Ontario, 2024

Note:
Data for these indicators are based on derived chronic condition cohorts developed at IC/ES using linked data algorithms. These measures of prevalence are measured among individuals 20 years or older, with the exception of asthma.

KEY OBSERVATIONS

Prevalence of chronic diseases in Niagara such as hypertension, asthma, and diabetes are showing upward trends indicating they are becoming more prominent.

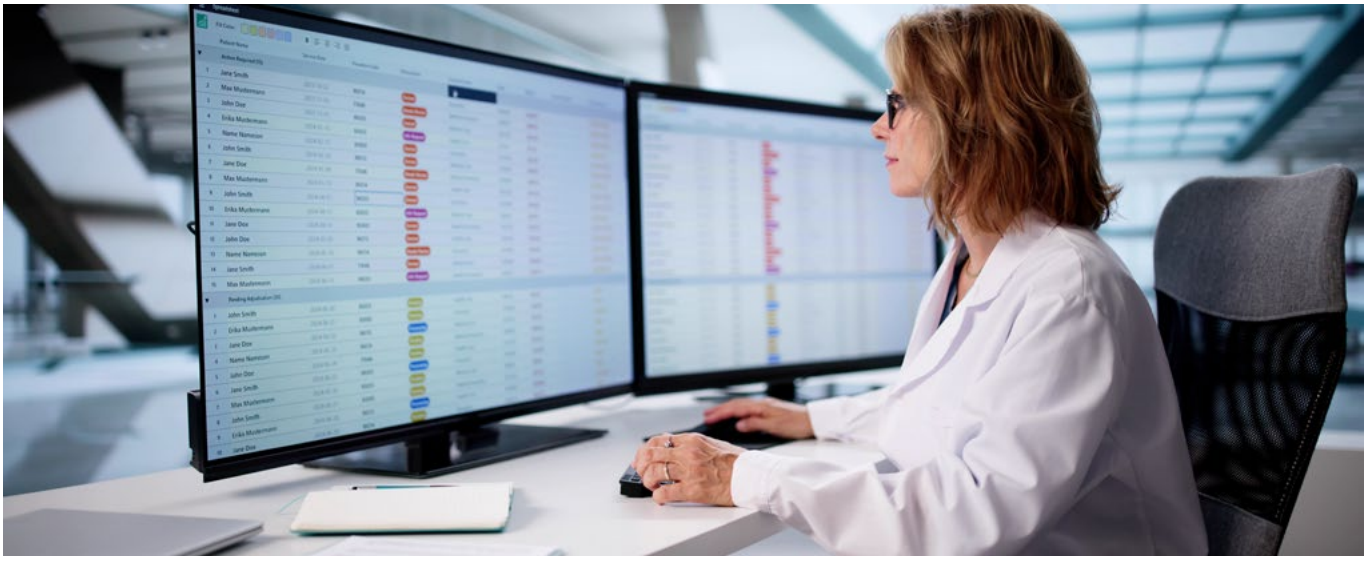
Compared to Ontario, in Niagara, there is a significantly lower prevalence rate of diabetes and significantly higher rates of asthma, COPD and hypertension.

Asthma is more common among 20- to 44-year-olds otherwise, all other diseases are more common in older populations (65 years or older).

[9] Parnar et al., (2022). Impact of cancer surgery slowdowns on patient survival during the COVId-19 pandemic: a microsimulation modelling study. CMAJ, 194. doi: 10.1503/cmaj.202380

[10] Eskander at al., (2022). Incident Cancer Detection During the COVID-19 Pandemic. J Natl Compr Canc Netw 2022;20(3):276–284. doi: 10.6004/jnccn.2021.7114

[11] CCO and Ontario Agency for Health Protection and Promotion (Public Health Ontario). The burden of chronic diseases in Ontario: key estimates to support efforts in prevention. Toronto: Queen's Printer for Ontario; 2019.



CHRONIC DISEASE PREVALENCE RATES BY SEX

Data Source:
Public Health Ontario, 2024

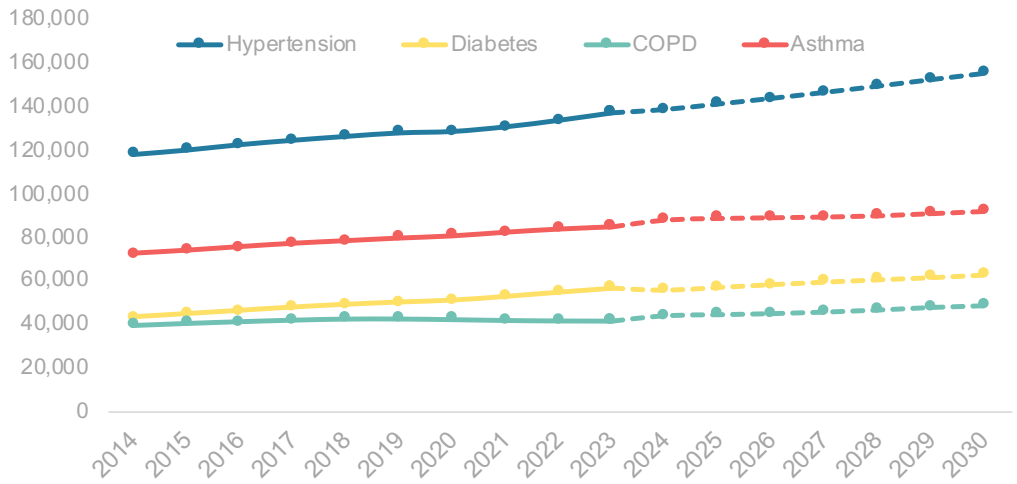
KEY OBSERVATIONS

In 2023, there were significantly more males than females with diabetes and hypertension while there were significantly more females than males with asthma.

THE CHRONIC DISEASE PROJECTIONS FROM 2014 TO 2030 SHOWS HYPERTENSION IS AND WILL CONTINUE TO BE THE MOST REPORTED DISEASE

Data Source:
Public Health Ontario, 2024; Ontario Ministry of Finance, 2025

Note:
Projections use prevalence-based methods and account for both population growth and population aging



KEY OBSERVATIONS

As of 2023, there were 137,095 cases of hypertension in Niagara. Based on population growth and aging patterns, it is projected that there will be 155,620 cases by 2030; this represents a 13.5 per cent increase.

Asthma will have a 7.8 per cent increase; diabetes will have a 10.5 per cent increase and COPD will have a 17.0 per cent increase.

CHRONIC DISEASE PROJECTIONS IN ONTARIO[12]

[12] Rosella, L. C., Buajitti, E., Daniel, I., Alexander, M., & Brown, A. (2023). Projected patterns of illness in Ontario. Ontario Hospital Association.

- The number of adults over 30 years in Ontario living with at least one major illness is projected to increase from 1.8 million in 2020 to an estimated 3.1 million in 2040. This means by 2040, about one in four adults 30 years or older will have a major illness — up from approximately one in eight in 2002.
- Conditions strongly associated with aging — such as osteoarthritis, diabetes, cancer, dementia, hearing loss — are expected to see particularly large increases. The demographic driver is predominantly an aging population. Life expectancy is increasing (around 81.5 years as of 2020–2022), contributing to more people living into older age, where chronic conditions accumulate. In addition, underlying social and structural risk factors (social determinants of health), and rising chronic-disease risk factors, also feed into the projected increases.
- The projected growth in chronic diseases and multimorbidity will place unprecedented strain on Ontario's health-care system. Implementing evidence-informed chronic disease management models can support better health outcomes for older adults and help mitigate growing pressures across hospitals, long-term care, and community care settings.
- Although there are currently no sub-provincial results, future analysis aims to provide sub-provincial results while also incorporating more sociodemographic data. It is reasonable that Niagara will experience some of the burden outlined the provincial analysis.

SO WHAT?

Chronic diseases such as hypertension, asthma, diabetes and COPD are increasingly common in Niagara and are projected to continue rising due to the region's aging population and underlying behavioural and social determinants of health. These conditions contribute to growing complexity in the health needs of residents, with older adults and individuals experiencing socioeconomic challenges disproportionately affected. These trends are important for understanding where population health needs are most concentrated and provide important context for interpreting system demand.

TOP HEALTH CONDITIONS AND DISEASES IN NIAGARA

In 2023, NRPH conducted an analysis[13] to identify the health conditions in Niagara of greatest burden using both quantitative and qualitative criteria. This analysis found that the top health five health conditions and diseases are:

- ISCHEMIC HEART DISEASE
- ACCIDENTAL FALLS
- CHRONIC LOWER RESPIRATORY DISEASES
- DIABETES
- CEREBROVASCULAR DISEASE

The results of the analysis also showed the diseases with largest increase in burden since 2019 are:

- CHRONIC LOWER RESPIRATORY DISEASES
- ACCIDENTAL POISONINGS
- DEMENTIA AND ALZHEIMER'S DISEASE

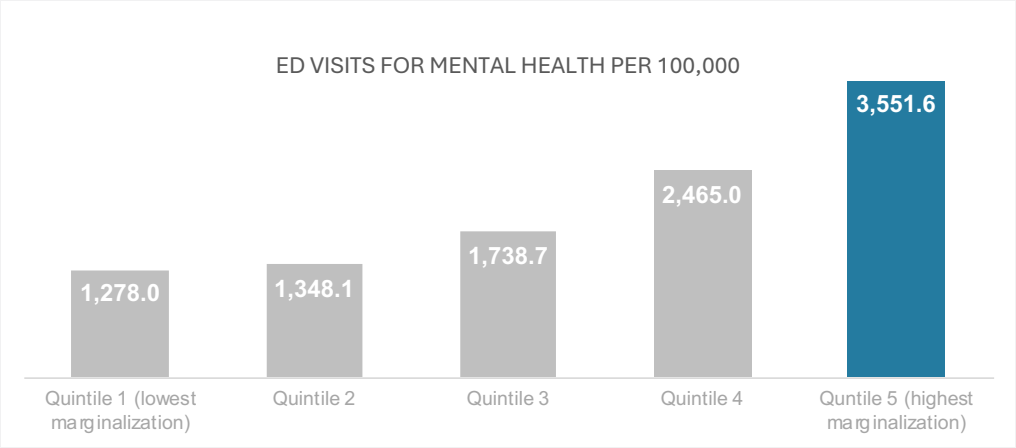
[13] Niagara Region Public Health & Emergency Services and Emergency Services (2023). Community Health Status Assessment. Thorold, Ontario.

For a full list of the top health conditions and diseases in Niagara, see Appendix B.

ONGOING HEALTH ISSUES

MENTAL HEALTH AND SUBSTANCE USE

Individuals with the highest level of material marginalization experience the highest rates of Emergency Department (ED) visits for mental health.



Data Source:
Public Health Ontario, 2022; National Ambulatory Care Reporting System, 2022

Note:
Rates are age-standardized per 100,000 population. Material deprivation or material resources refers to the limited access to and ability to attain basic material needs such as adequate income, education, and housing.

KEY OBSERVATIONS

Those with the highest marginalization or in quintile 5 have 3,551.6 per 100,000 ED visits, while those with the lowest marginalization or in quintile 1 have 1,278 per 100,000 ED visits. This is an excess of 2,273.6 per 100,000 ED visits due to being in different marginalization quintiles. This disparity is larger than the provincial average.

MENTAL HEALTH AND SUBSTANCE USE ADMISSIONS

Data Source:
Canadian Institute for Health Information, 2025

Notes:
[1] Risk-adjusted percentage of individuals who had three or more episodes of care for mental health and substance use (MHSU) disorders among all those who had at least one episode of care for MHSU disorders in general or psychiatric hospitals within a given year.

[2] Captures both suicidal and non-suicidal self-harm within the hospitalization data where intentional self-harm was noted. Injuries coded as accidental or undetermined are not included. Data captures the 2024-2025 fiscal year for Niagara.

12.9%[1]

Repeat hospital stays for mental health and substance use

69
PER 100,000[2]

Inpatient admissions for self-harm

12.4
PER 100

30-day readmission for mental health and substance use

Repeat hospital stays for mental health and substance use in Niagara (12.9 per cent) are similar to Ontario (13.7 per cent).

Inpatient admissions for self-harm in Niagara (69.0 per 100,000) are significantly higher compared to the rest of Ontario (53.0 per 100,000).

30-Day readmission for mental health and substance use in Niagara (12.4 per 100) is significantly lower compared to the rest of Ontario (14.5 per 100).

ONGOING HEALTH ISSUES

OPIOID USE IN NIAGARA

Indicator	2022	2023	2024
Counts			
ED visits	581	607	643
Hospitalizations	101	98	108
Deaths	125	133	110
Rates per 100,000 population			
ED visits per 100,000	114.2	115.5	117.9
Hospitalizations per 100,000	19.9	18.7	19.8
Deaths per 100,000	24.6	25.3	20.2

Data Source:
Public Health Ontario (PHO): Substance Use and Harms Tool, 2025, National Ambulatory Care Reporting System (NACRS), 2025; Discharge Abstract Database (DAD), 2025; Office of the Chief Coroner for Ontario/ Ontario Forensic Pathology Service (OCC/OFPS), 2025

Note:
Deaths can include more than one drug as a cause; the percentage attributed to any one drug is calculated using the total number of unique deaths.

Note: Consumption and Treatment Services Site
There is currently one Consumption and Treatment Services site in Niagara, operating since December 2018. The site is in St. Catharines and is available for those as needed. Adjacent services are also available, which include wound care and referrals to other services.

KEY OBSERVATIONS

- Opioid use related Emergency Department (ED) visits in Niagara continue to be higher compared to the rest of Ontario. In 2024, there were 117.9 per 100,000 ED visits in Niagara compared to 77.1 per 100,000 in Ontario; this is 1.5 times higher, representing approximately 40 additional individuals per 100,000. Groups most affected include males (65.2 per cent) between the ages of 25 to 44 years (52.1 per cent); this has been consistent over time.
- Opioid use related hospitalizations in Niagara also continue to be higher compared to the rest of Ontario. In 2024, there were 19.8 per 100,000 hospitalizations in Niagara compared to 12.9 per 100,000 in Ontario; this is 1.5 times higher, representing approximately seven additional individuals per 100,000. Groups most affected include males (61.1 per cent) between the ages of 45 to 64 years (45.4 per cent); these age groups are slightly higher compared to previous years.
- Deaths from Opioid toxicity show an upward trend and continue to be higher compared to the rest of Ontario. In 2024, there were 20.2 per 100,000 deaths in Niagara compared to 13.9 per 100,000 in Ontario. This is 1.4 times higher, representing approximately six additional individuals per 100,000. Groups most affected include males (70 per cent) between the ages of 25 to 44 years (58.1per cent); these are consistent with the province.
- Data indicates that the majority of deaths are caused by fentanyl (82.7 per cent) followed by methadone (14.5 per cent) and hydromorphone (4.5 per cent); these trends are consistent over time and similar to Ontario.
- Historical data show that opioid use is more prevalent in areas where individuals are marginalized. Niagara's position as a border region also contributes to the crisis, as it increases the supply and availability of opioids in the community.
- To minimize mortality and severe harms, harm reduction strategies such as Naloxone kits are vital. In 2024, 59,404 kits were distributed, which is part of an increasing trend over the last several years.

SO WHAT?

Opioid-related harms in Niagara remain consistently higher than provincial rates across ED visits, hospitalizations and deaths. These deaths disproportionately affect males and adults aged 25 to 44 years and 45 to 64 years and are closely linked to underlying factors such as housing instability, material deprivation, and co-occurring mental health challenges. Niagara's opioid patterns also mirror broader substance use trends described earlier in this section. Understanding these patterns is essential for interpreting the types of health needs that disproportionately rely on urgent and acute care, and highlights the importance of coordinated approaches to prevention, harm reduction, and mental health and addiction supports across the region.

COMMUNICABLE AND INFECTIOUS DISEASES

Infectious and communicable diseases continue to pose a significant challenge to population health, with both emerging (novel) and re-emerging (coming back after a decline) pathogens. Despite advancements in surveillance, immunization and public health infrastructure, outbreaks of respiratory illnesses, vaccine-preventable diseases, and gastrointestinal (enteric) infections continue to occur. The burden is often disproportionately felt among marginalized populations, where barriers to healthcare access and broader social conditions can increase vulnerability.

This section provides a high-level overview of communicable disease trends most relevant to understanding population health patterns across Niagara. Detailed case numbers, risk factors and five-year trends for vector-borne diseases, food and waterborne diseases, and sexually transmitted infections are available in Appendix B.

VECTOR-BORNE DISEASES

Vector-borne diseases such as Lyme disease and West Nile Virus continue to be monitored in Niagara. Case numbers remain relatively low but may fluctuate year-to-year and are influenced by climate and environmental changes. Ongoing surveillance is required to detect emerging risks and ensure timely public health response.

FOOD AND WATERBORNE DISEASES

Food and waterborne illnesses continue to occur in Niagara and are most often linked to Campylobacter, Salmonella, Cryptosporidium, and Giardia. These infections can result from contaminated food or water or from improper food handling. Outbreaks occur periodically throughout the year, especially in long-term care, retirement homes, and other congregate settings. While most illnesses are mild, monitoring is important to detect changes in local trends and to support timely public health action.

Data Source:
Integrated Public Health Information System (iPHIS), 2025

[14] COVID-19 and Influenza are measured as positive tests instead of cases. This is due to changes in provincial reporting requirements. As such, interpret data with caution when comparing results to other diseases.

[15] Latent TB infection (LTBI) is the presence of latent or dormant infection with Mycobacterium tuberculosis with no evidence of clinical disease. Medical surveillance is a medical check-up for a person who has newly arrived in Canada, to check that their inactive tuberculosis has not progressed to active tuberculosis disease.

DIRECT CONTACT/RESPIRATORY DISEASES

COVID-19 is still the predominant direct contact/respiratory disease. In 2024, there were 3,021 cases of COVID-19 and 1,052 cases of Influenza. COVID-19 episodes occur mostly among those 60 years and older. Other common direct contact and respiratory diseases in 2024 include: 74 cases of Group A Streptococcal Disease, Invasive (iGAS), 16 cases of Legionellosis, and 14 cases of Active Tuberculosis.[14] Episodes of latent tuberculosis and medical surveillance are rising steadily in Niagara. In 2024, there were 477 cases of Latent Tuberculosis, and 243 cases of Medical Surveillance compared to in 2019, there were 184 cases of Latent Tuberculosis and 85 cases of Medical Surveillance.[15]

VACCINE-PREVENTABLE DISEASES

Streptococcus Pneumoniae is historically and currently still the most reported vaccine preventable disease (83 cases in 2024). This is followed by Pertussis (whooping cough) with 32 cases, Haemophilus Influenzae Disease with 18 cases, Varicella (chicken pox) with 13 cases and Hepatitis B with three cases. Streptococcus Pneumoniae cases are reported mostly among males and those age 60 years or older. The most reported risk factors for Streptococcus Pneumoniae include alcohol abuse, existing chronic illness or underlying medical condition and substance use. Over the past five years, there are three noticeable trends, generally indicating rates are increasing, but are like the rest of Ontario: Increase in Streptococcus Pneumoniae cases since 2021; increase in Varicella cases since 2023; and re-emergence of Pertussis cases in 2024.

SO WHAT?

Communicable diseases in Niagara continue to fluctuate from year to year, influenced by variations in vaccination coverage, seasonal respiratory activity, environmental exposures, and differences in social and demographic characteristics across communities. These conditions do not affect all residents equally. Populations facing socioeconomic barriers, lower immunization uptake, or greater exposure risks experience higher impacts. Understanding these patterns helps identify where vulnerabilities exist and where targeted surveillance, outreach, and prevention efforts may be most beneficial.

EMERGING HEALTH ISSUE

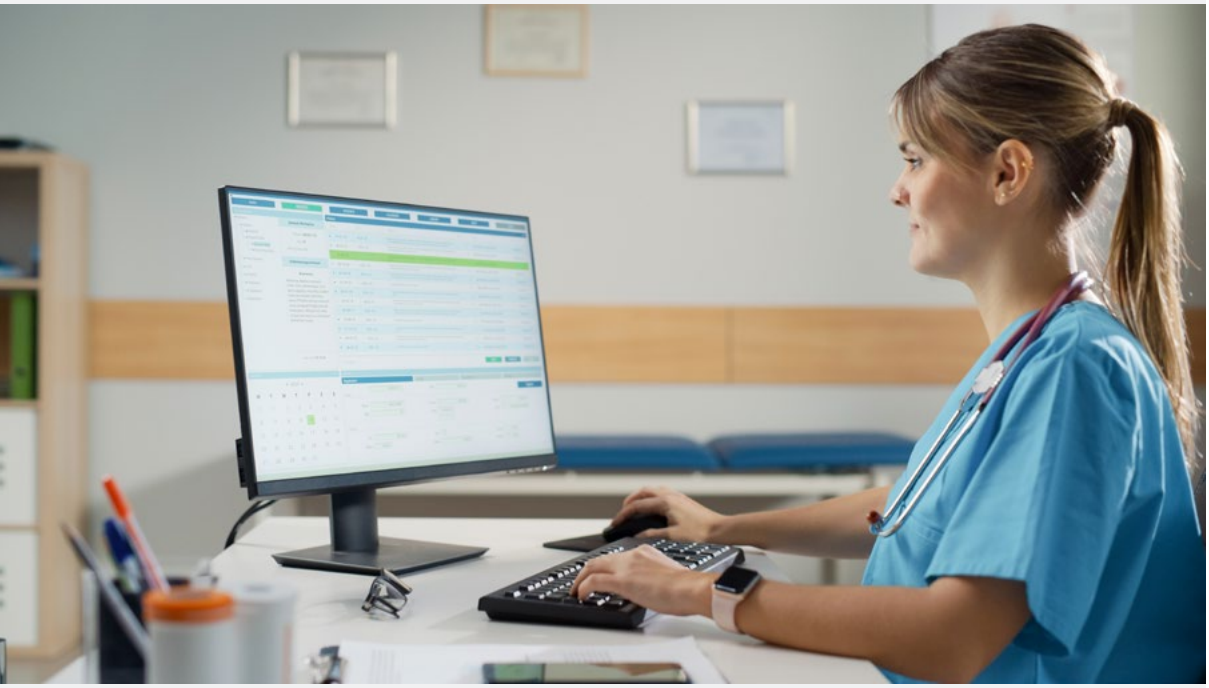
RE-EMERGING VACCINE-PREVENTABLE DISEASES

Niagara recently experienced increases in measles and pertussis cases, both of which are vaccine-preventable diseases that have seen resurgence in many jurisdictions. Thirteen cases of measles occurred this past year while 32 cases of Pertussis were reported in 2024; in both instances, this is higher than normal.

Data Source:
Infectious Disease (ID) Query, 2025; integrated Public Health Information System (iPHIS), 2025; Niagara Region Public Health, 2025

Measles (2025):

- Nine or 69.2 per cent of measles cases are male
- 11 or 84.6 per cent of measles cases are under 20 years old
- The average age of cases is 15.1 years old
- Among measles cases, the most common risk factors include being a member of an under-immunized community, being partially or unimmunized



Pertussis (2024):

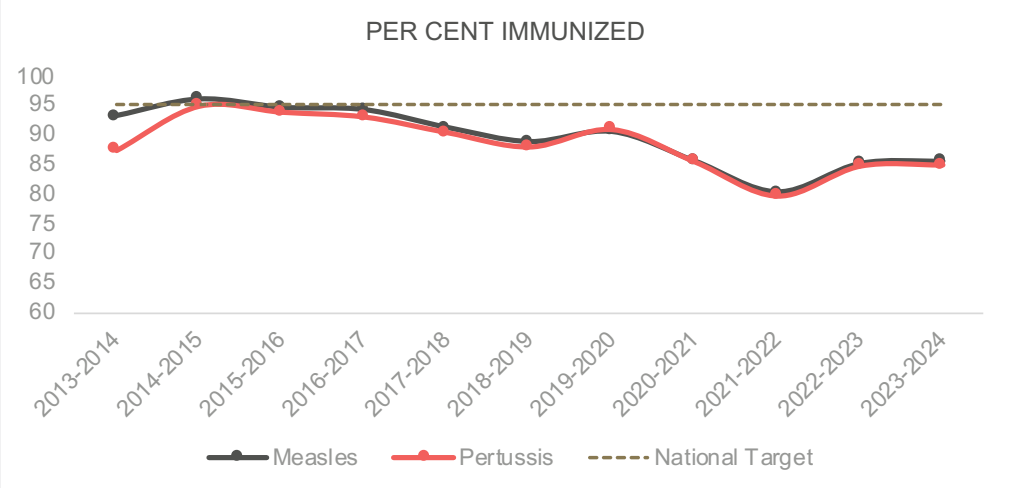
- 17 or 53.1 per cent of pertussis cases are female
- 25 or 78.1 per cent of pertussis cases are under 20 years-old
- The average age of cases is 13.5 years-old
- Among pertussis cases, the most common risk factors include being partially or unimmunized, and travel

Case Management Workload:

- Diseases such as measles require extensive follow-up by Public Health Nurses, including repeated engagement with confirmed cases, contacts, and probable cases that are never confirmed. Each case can therefore require multiple layers of follow-up and sustained interaction, underscoring the significant workload involved.
- For example, among the 13 cases of measles in Niagara in 2025, this resulted in: 1,183 interactions with clients (34 with confirmed cases, 620 with contacts of cases, and 529 with cases that were under investigation but confirmed later). For each confirmed measles case, there was an average of nearly 19 contacts.

EMERGING HEALTH ISSUE

VACCINATION COVERAGE AGAINST ANTIGENS (SEVEN-YEAR-OLDS)



Data Source:
Public Health Ontario: Immunization Data Tool, 2025;
Panorama Enhanced Analytical Reporting (PEAR), 2025

KEY OBSERVATIONS

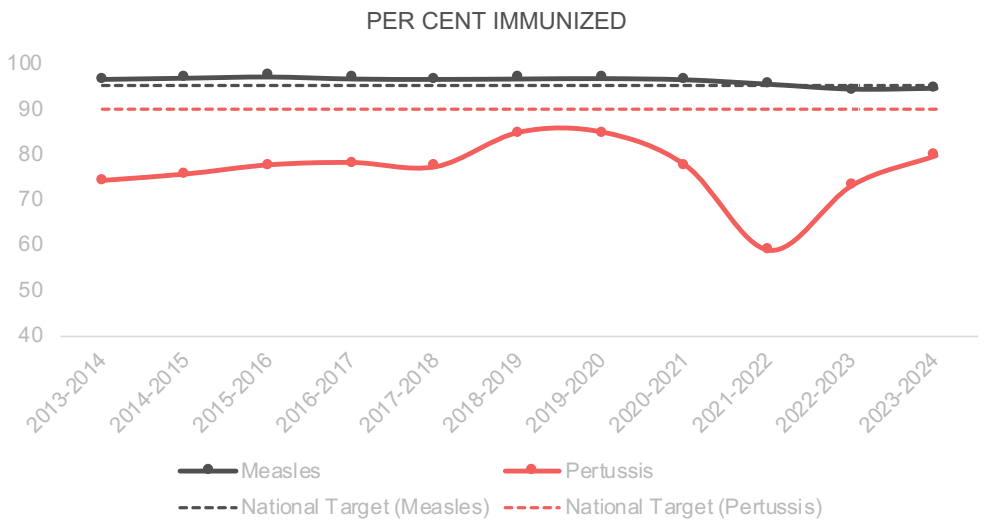
During the 2023-24 school year, 85.5 per cent of Niagara seven-year-olds were vaccinated against measles

- Trends suggest vaccination coverage is declining over time with a dip in 2018-19 and again in 2021-2022; currently vaccination coverage in Niagara is below national targets
- The vaccination coverage for measles in Niagara (85.5 per cent) is higher compared to the rest of Ontario (70.4 per cent); an observable difference since the 2020-2021 school year

During the 2023-24 school year, 85 per cent of Niagara seven-year-olds were vaccinated against pertussis

- Trends suggest vaccination coverage for pertussis in Niagara are like patterns observed for measles coverage
- The vaccination coverage for pertussis in Niagara (85 per cent) is higher compared to the rest of Ontario (69.8 per cent); an observable difference since the 2020-2021 school year

VACCINATION COVERAGE AGAINST ANTIGENS (17-YEAR-OLDS)



Data Source:
Public Health Ontario: Immunization Data Tool, 2025;
Panorama Enhanced Analytical Reporting (PEAR), 2025

KEY OBSERVATIONS

During the 2023-24 school year, 94.3 per cent of Niagara 17-year-olds were vaccinated against measles.

- Trends suggest vaccination coverage has slightly declined over time but there were no large dips observed; currently coverage in Niagara is slightly below national targets.
- Niagara (94.3 per cent) has slightly higher vaccination coverage for measles compared to the rest of Ontario (91.6 per cent); although not a large gap, this size has been observed since the 2021-22 school year.
- During the 2023-24 school year, 79.5 per cent of Niagara 17-year-olds were vaccinated against pertussis.
- Trends suggest vaccination coverage for pertussis in Niagara is lower than measles, with a large dip in the 2021-22 school year; it has since recovered. Currently coverage in Niagara is below national targets.
- Niagara (79.5 per cent) has higher vaccination coverage for pertussis compared to the rest of Ontario (63.0 per cent).

SO WHAT?

Recent increases in measles (13 cases in 2025) and pertussis (32 cases in 2024) in Niagara, concentrated among youth and linked to under-immunization, highlight the risks posed by declining vaccination coverage. While local coverage rates remain higher than the Ontario average, they are below national targets and show downward trends, particularly for pertussis. These trends suggest that broader immunization patterns should be monitored to identify communities or age groups that may benefit from targeted outreach or enhanced public health engagement. Understanding these patterns also helps anticipate where prevention efforts may need to be strengthened to maintain protection against vaccine-preventable diseases and reduce the likelihood of future outbreaks.

INSIGHT

HOW DO DEMOGRAPHIC AND POPULATION HEALTH PATTERNS RELATE TO HEALTH SYSTEM CAPACITY?

Niagara's population profile and health status reveal several patterns that have important implications for interpreting demand across the continuum of care. These insights summarize how demographic shifts, risk behaviours, chronic disease trends, mental health needs, communicable disease patterns, and emerging vaccine-preventable issues relate to the four components of health system capacity used throughout this report.

STUFF
RESOURCES, DIAGNOSTICS, SUPPLIES

CURRENT STATE:

- Chronic diseases such as hypertension, diabetes, COPD, and asthma are already prevalent and increasing
- High naloxone distribution reflects sustained opioid exposure and ongoing need for overdose prevention efforts across the community
- Seasonal respiratory viruses and communicable diseases continue to circulate annually, with vaccination coverage showing variability across age groups and antigens

IMPLICATIONS:

- Sustained demand for diagnostics (imaging, lab testing), chronic disease management tools, and mobility aids
- Continued requirement for harm-reduction supplies to prevent severe opioid-related outcomes
- Reliable access to testing materials, vaccines, and outbreak-response supplies remains essential to support immunization delivery and manage seasonal and outbreak-related pressures
- Income-related barriers may limit equitable access to some health-related equipment

SPACE
SERVICE LOCATIONS AND DISTRIBUTION

CURRENT STATE:

- Niagara's population is aging rapidly, with more than 23,000 additional adults 65 years or older expected by 2030
- Neighbourhood-level deprivation varies significantly across the region
- Chronic disease and mental-health burdens differ by community

IMPLICATIONS:

- Increased demand for primary care, community clinics, home and community care, and long-term care capacity
- Certain municipalities may require greater access to preventative and chronic disease supports
- Population variation suggests service distribution must consider local context and equity
- Seasonal communicable-disease activity requires flexible public health and primary-care spaces
- Aging in place will require supportive community infrastructure, including accessible housing and transportation

STAFF
WORKFORCE

CURRENT STATE:

- Chronic diseases, multimorbidity, and aging are increasing
- Mental-health concerns are prevalent, with high ED use among marginalized populations
- Public health manages ongoing case and outbreak investigations
- Niagara has linguistic and cultural diversity

IMPLICATIONS:

- Growing need for workforce capacity in primary care, geriatrics, chronic disease management, rehabilitation, home care, and long-term care
- Greater demand for mental health and addictions providers across community and acute settings
- Outbreak and communicable disease response requires significant public health nursing capacity (for example, 13 measles cases equate to over 1,100 interactions for case and contact management)
- Multidisciplinary teams are increasingly needed for prevention and risk-reduction efforts
- Culturally and linguistically informed service delivery must be supported through staffing

SYSTEMS
COORDINATION, SURVEILLANCE, PREVENTION PATHWAYS

CURRENT STATE:

- Chronic disease, mental health, and opioid harms place ongoing pressure on prevention and support systems
- Vaccination coverage shows declining or fluctuating trends
- Communicable diseases continue to emerge and re-emerge
- Neighbourhood inequities influence access and outcomes

IMPLICATIONS:

- Integrated pathways across primary care, public health, community care, and acute care are essential
- Surveillance and immunization systems must remain robust and responsive
- Emerging and re-emerging infectious diseases reinforce the importance of coordinated surveillance systems, timely reporting, and inter-sector collaboration
- Equity-oriented planning is needed to ensure system design reflects local population needs
- Opioid-related harms require coordinated approaches across sectors for prevention and follow-up care

3 SYSTEM RESOURCES AND HEALTHCARE UTILIZATION

This section provides a summary of the system resources and healthcare utilization patterns in Niagara across the following: primary care, emergency services, hospitals, hospice, long-term care and other community health services.

PRIMARY CARE

Primary care serves as the foundation of a strong and sustainable health system, playing a critical role in prevention, early intervention, chronic disease management, and care coordination. Its capacity directly influences system performance, access to services, and health equity. However, challenges such as workforce shortages, uneven geographic distribution, and increasing service demand continue to strain primary care resources. Strengthening primary care infrastructure, including team-based models, digital health integration and community partnerships is essential to enhancing system resilience and ensuring prompt, person-centered care.

PRIMARY CARE BY THE NUMBERS

Data Source:
Ministry of Health, 2025; Corporate Provider Database (CPDB), 2025

252
Practicing family physicians in Niagara region

1 TO 1,371
Physician-to-patient ratio

345,435
Number of enrolled patients

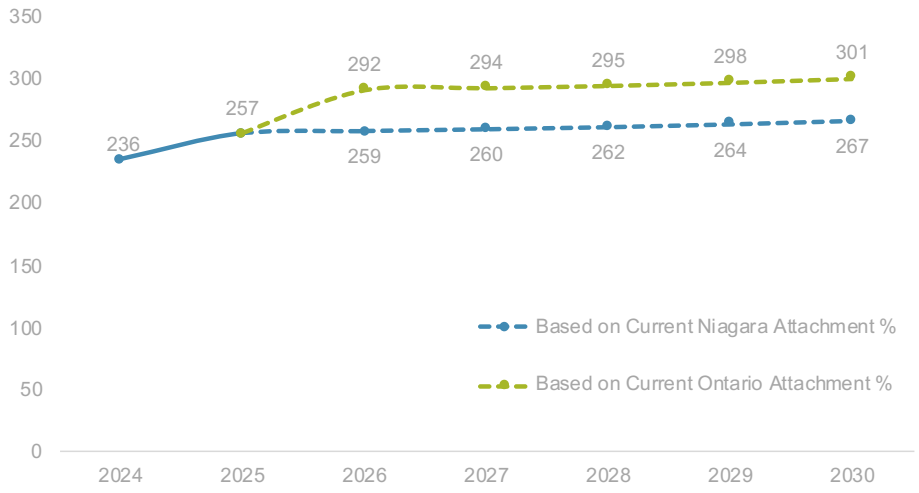
23.7%
Practicing physicians 60 years-old or older

As of February 2025:

- There are 16 more practicing physicians compared to January 2024
- There are 15,527 more patients enrolled with a family physician compared to January 2024
- Each family physician has 1,371 enrolled patients, down from 1,398 in January 2024 — a net decrease of 27 patients per physician
- 24.6 per cent or 61 physicians are 60 years or older: 8.9 per cent or 22 physicians are between 60 to 64 years old, and 15.7 per cent or 39 physicians are 65 years old and older

NUMBER OF PHYSICIANS NEEDED IN NIAGARA BY 2030

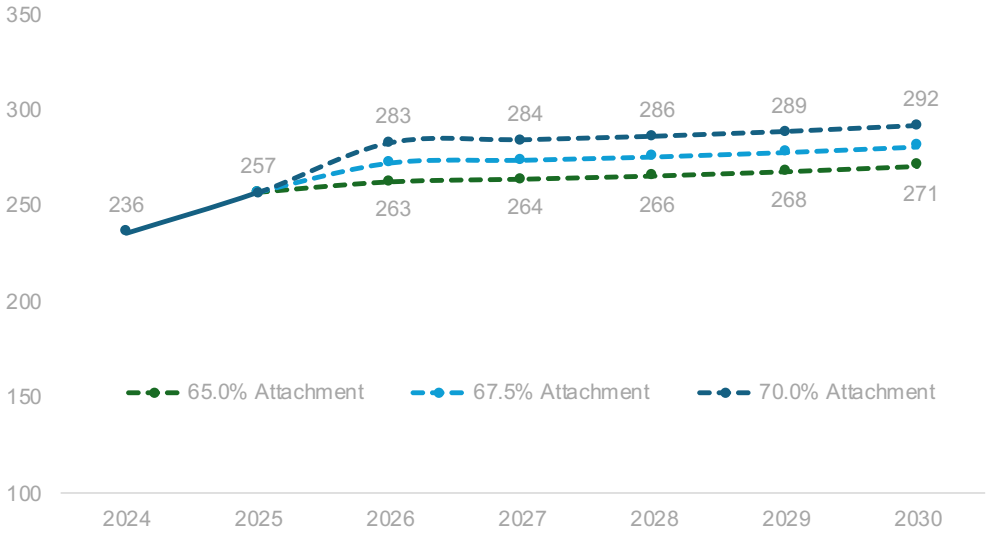
Data Source:
Corporate Provider Database (CPDB), 2025; Client Agency Program Enrolment (CAPE), 2025



- As of July 2025, there are 257 practicing physicians in Niagara, with 64 per cent of residents attached to a physician
- If there is interest in maintaining the current patient-to-physician ratio, Niagara would need 10 additional or a total of 267 practicing physicians by 2030
- If there is interest in aligning with the provincial patient-to-physician ratio, Niagara will need 44 additional or a total of 301 practicing physicians by 203.
- Although there is no universally ideal physician-to-patient ratio, the goal is to keep ratios lower to reduce wait times and improve access to care

PHYSICIANS NEEDED BASED ON ATTACHMENT GOALS

Data Source:
Corporate Provider Database (CPDB), 2025; Client Agency Program Enrolment (CAPE), 2025



KEY OBSERVATIONS

If Niagara would like to achieve 65.0 per cent, 67.5 per cent or 70.0 per cent attachment rates by 2030, there would need to be 271, 281 and 292 practicing physicians, respectively

SO WHAT?

Niagara's primary care workforce is growing modestly but remains below what is needed for long-term sustainability. Retirement risk among physicians 60 years and older threatens future supply, and projections show a need for 10 to 44 additional physicians by 2030, depending on targets. To meet these targets, physician recruitment and retention must be prioritized, particularly attracting younger physicians, supporting practice establishment in underserved areas, and ensuring competitive incentives. Without strategic recruitment, Niagara risks widening gaps in primary care access, increasing reliance on emergency services, and constraining overall health system capacity.

UNATTACHED TO PRIMARY CARE POPULATION

A growing segment of the population remains "unattached" to a regular primary care provider, posing significant challenges to continuity of care, timely access to health services, and overall health outcomes. Individuals without a dedicated provider often rely on walk-in clinics or emergency departments for episodic care, which can lead to fragmented service delivery, missed opportunities for prevention and early intervention and strains on the overall system. This issue disproportionately affects newcomers, individuals experiencing socioeconomic barriers, and those living in rural or underserved areas.

UNATTACHED TO PRIMARY CARE POPULATION BY THE NUMBERS

306,508
Number of patients who are attached or have regular primary care

52,889
Number of patients who are unattached or do not have regular primary care

37
Median age (in years) of those unattached or without regular primary care

Data Source:
INSPIRE PHC, 2022

Note:
Population count is based on those who fall under the Niagara Ontario Health Team catchment area. "Attached" refers to patients who have a regular source of primary care if they meet one or more conditions: (1) rostered to a family physician/ team in an enrollment model; (2) virtually rostered to a family physician; (3) visits to a Community Health Centre (CHC) in the last 2 years, and (4) assignments of virtually rostered children (under the age of 19) to a pediatrician/family doctor. "Unattached" refers to patients who do not have a regular source of primary care and do not meet any of the above four conditions mentioned above.

52,889 or 14.7 per cent of individuals report not having a regular source of primary care. Niagara ranks 12th out of 56 Ontario Health Teams with the highest unattachment

Among individuals attached to primary care, 57.6 per cent are male, which is higher than the 47.6 per cent of males who are unattached. Moreover, 52.9 per cent of unattached individuals are aged 18 to 49 years, compared to 35.7 per cent among those who are attached.

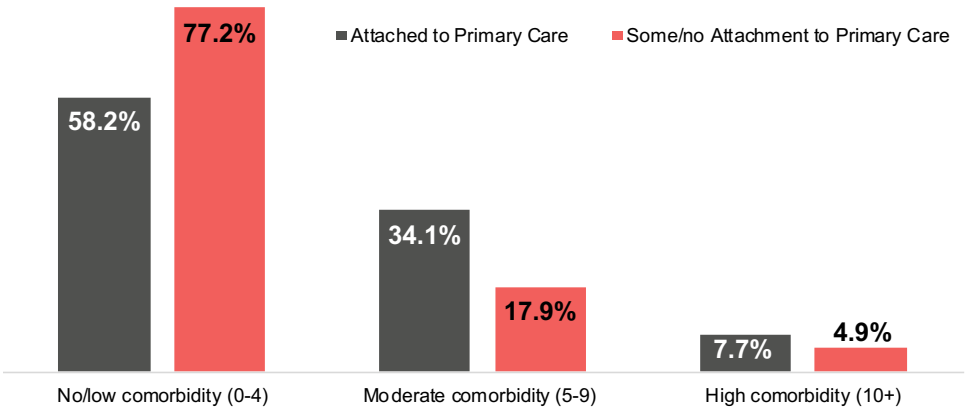
Among those unattached:

- 23,395 or 44.2 per cent report being unaffiliated with the doctor but they had one or more primary care visits in last two years
- 29,494 or 55.8 per cent report being unaffiliated with the doctor and they did not receive any primary care services in last two years
- There are slightly higher percentages of individuals who are unattached that are in the worst quintile for material resources/ deprivation (29.0 per cent vs 24.4 per cent) and residential/housing instability (23.5 per cent versus 19.0 per cent)

COMORBIDITY BY PRIMARY CARE ATTACHMENT STATUS

Data Source:
INSPIRE PHC, 2022

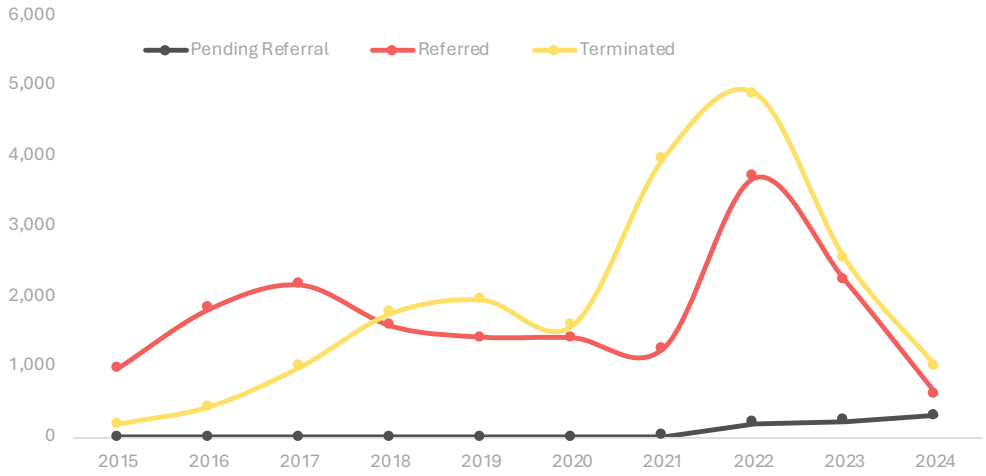
Note:
Comorbidities are measured using the Johns Hopkins Aggregated Diagnosis Groups (ADGs). ADGs are derived by assigning individuals into one of the 32 diagnosis clusters based on five clinical dimensions. Individuals are categorized these clusters into three comorbidity groups: 0-4 (none/low), 5-9 (moderate) and 10+ (high).



KEY OBSERVATIONS

Comorbidity by attachment status suggests that those who are unattached experience less comorbidities than those who are attached. Among those who are attached, there are 16.2 per cent more individuals with moderate comorbidities and 2.8 per cent more individuals with high comorbidities.

REGISTRATION FOR FINDING PRIMARY CARE AMONG NIAGARA RESIDENTS



Data Source:
Capacity Planning and Analytics Division (CPAD), 2025; Health Care Connect, 2025

Note:
Registrations only count the number of individuals who apply; this is not a representation of all individuals in Niagara without access to primary care. Data current as of October 2025.

In 2024, there were 1,909 registrations through Health Care Connect to find a family physician or nurse practitioner in Niagara: 419 are considered complex vulnerable individuals and 1,490 are considered non-complex vulnerable individuals

- Among the 1,909 registrations, 605 were referred and found primary care, 1,000 were terminated and removed themselves from the list, and 304 are still currently waiting

Wait times vary however, in 2024, 77.7 per cent of registrants found a primary care provider within 20 days; 8.2 per cent found a primary care provider in 21 to 60 days and 7.0 per cent in 131 to 260 days. This is generally consistent over time.

SO WHAT?

Niagara faces challenges with primary care attachment: nearly 53,000 residents (14.7 per cent) report no regular source of care, ranking 12th highest among Ontario Health Teams. While Health Care Connect demonstrates strong performance in quickly linking patients to providers – most within 20 days, capacity gaps remain, with hundreds still waiting and many unattached individuals disengaged from care altogether. Unattachment is more common among younger adults and residents living in high-deprivation neighbourhoods, and it may disproportionately affect newcomers and other marginalized groups who face additional structural and access barriers.

Unattached patients report fewer comorbidities, which may reflect either a lower perceived need for care or undiagnosed conditions that will surface later as more complex demands on the system. These patterns highlight important considerations for understanding population needs, service utilization, and where pressures may arise across the health system.

FAMILY HEALTH TEAMS/ COMMUNITY HEALTH CENTRES

Family Health Teams (FHTs) are primary care organizations where family physicians work alongside nurses, social workers, dietitians, pharmacists, and other professionals to provide coordinated, team-based care, while Community Health Centres (CHCs) are non-profit, community-governed clinics that combine primary care with social services and focus on underserved populations. FHTs and CHCs offer broader, more integrated, and prevention-focused services designed to meet ongoing, everyday health needs within the community.

FHT/CHC BY THE NUMBERS

Data Source:
Niagara Ontario Health Team – Équipe Santé Ontario Niagara (NOHT-ÉSON) Primary Care Environmental Scan, 2025

72.7
Medical Doctor (MD) FTEs

92,025
Rostered patients among MDs

36.4
Nurse Practitioner FTEs

7,139
Rostered patients among NPs

Among the organizations that participated in the survey, several key questions were asked, including common barriers experienced by clients, the most common reasons for visits, and services that may be missing etc.

General findings include:

- Participating organizations include community health centres, family health teams and Indigenous primary health care organizations
- Participating organizations are generally based out of St. Catharines, Niagara Falls, Welland, Port Colborne, Fort Erie and Niagara-on-the-Lake
- Most organizations have the capacity to roster more patients
- There are 685 patients who are waitlisted as of September 2025

The most common challenges for patients include:

- Wait times for appointments
- Lack of access to programs and services, which include language and travel barriers
- Little awareness of services and programs available in the region
- Few providers who can roster patients who have more complex health issues

The most common health issues that patients present to their MD/NP:

- Mental health and/or substance use
- Wound care and various types of infections
- Assistance with forms/letters e.g. ODSP
- Conditions for chronic or acute pain
- Chronic disease management

Niagara needs additional allied health professionals across several areas, though some respondents noted it's hard to determine exact gaps without knowing whether current providers are being fully utilized. Key needs include more mental health clinicians (such as fully trained Master of Social Work (MSW) practitioners, Community Rehabilitation Providers (CRPs), and providers trained in Dialectical Behaviour Therapy (DBT), affordable access to dentistry, physiotherapy, chiropractic, osteopathy, and chiropody, as well as kinesiologists. Specialized roles are also needed for memory clinics—particularly OTs, RNs, and gerontologists—along with midwives, traditional healers, speech-language pathologists, and nurse practitioners with advanced skills such as colposcopy and DBT.

Respondents believe that Niagara is missing a wide range of specialty services, forcing patients to travel to Hamilton for care. Major gaps include mental health services—especially psychiatry, trauma counselling, and full assessment programs—as well as complex women's health, OB/GYN, midwifery, and gender-affirming care. Several medical specialties are limited or have long wait times, such as neurosurgery, neurology, dermatology (often restricted to suspected skin cancers), cardiology, HIV clinical care, and OHIP-covered plastic surgery. Pediatric subspecialties like orthopedics and cardiology are also lacking, along with residential treatment options, palliative care, and youth metabolic/ lifestyle management programs. Orthopedic surgery capacity is strained due to impending retirements, further contributing to service gaps.

SO WHAT?

Niagara's health system shows strong foundations in team-based primary care through Family Health Teams, Community Health Centres, and Indigenous organizations, but current capacity is strained, with nearly 100,000 rostered patients supported by just over 100 MD and NP FTEs and hundreds more waitlisted. Persistent barriers such as long appointment wait times, limited program access, language and transportation challenges, and shortages of providers for complex patients highlight misalignment between resources and community needs. At the same time, demand is rising for mental health, chronic disease management, pain care, and administrative support, while gaps in allied health professionals (such as mental health clinicians, rehabilitation providers, gerontology specialists, midwives, traditional healers) and specialty services (psychiatry, neurology, OB/GYN, pediatrics, dermatology, cardiology, HIV care, palliative care) force patients to travel outside the region. For health system planning, this signals an urgent need to expand workforce capacity, integrate allied and specialty care locally, and invest in culturally safe, accessible services to meet the growing complexity of Niagara's population.

EMERGENCY MEDICAL SERVICES

Emergency Medical Services (EMS) are a critical component of the health system, providing rapid response, stabilization, and transport for individuals experiencing acute medical emergencies. EMS plays a vital role in bridging community-based care with hospital services, particularly in rural and underserved areas where access to timely care may be limited. However, increasing call volumes, workforce pressures, and evolving patient needs are placing strain on EMS capacity and response times.

EMS BY THE NUMBERS

Data Source:
Niagara Navigator, 2025; Niagara Emergency Medical Services, 2025

77,551

Number of incidents reported that needed ambulance(s) in 2024

Most patients attended to by EMS are 65 years or older; the next age group are those between 25 to 64 years old

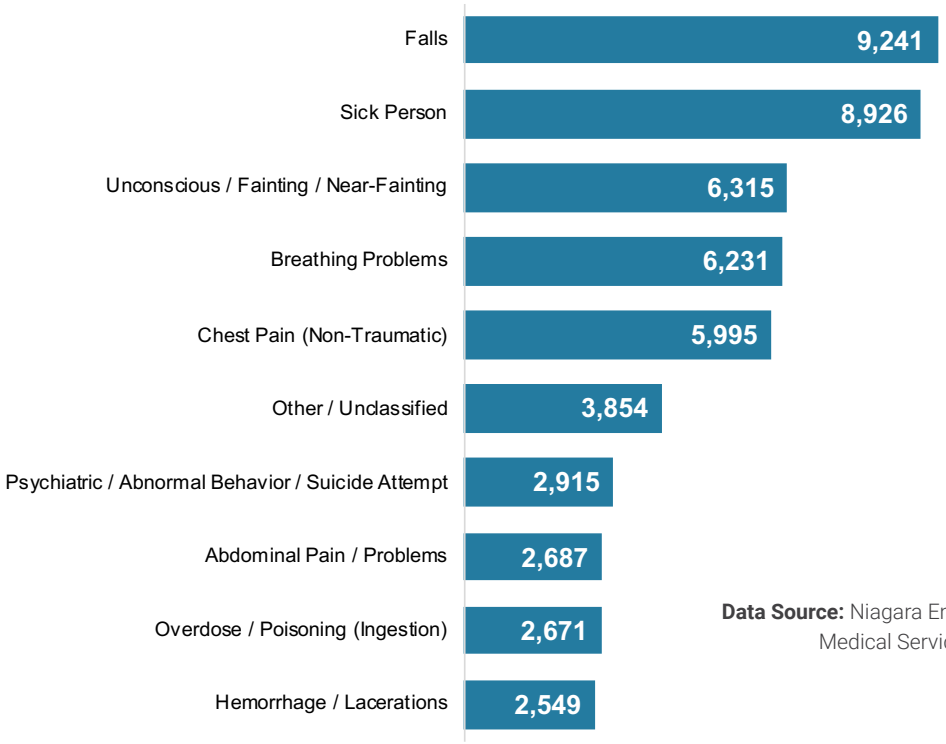
Trends are consistent over time with no noticeable changes

In 2024:

- Those 65 years or older made up 45.5 per cent of patients attended to by EMS
- Those between 25 to 64 years made up 37.4 per cent of patients attended to by EMS

See Appendix B.

"FALLS" AND "SICK PERSON" DISPATCH CODES ARE THE MOST COMMON REASONS FOR RESPONSES IN 2024

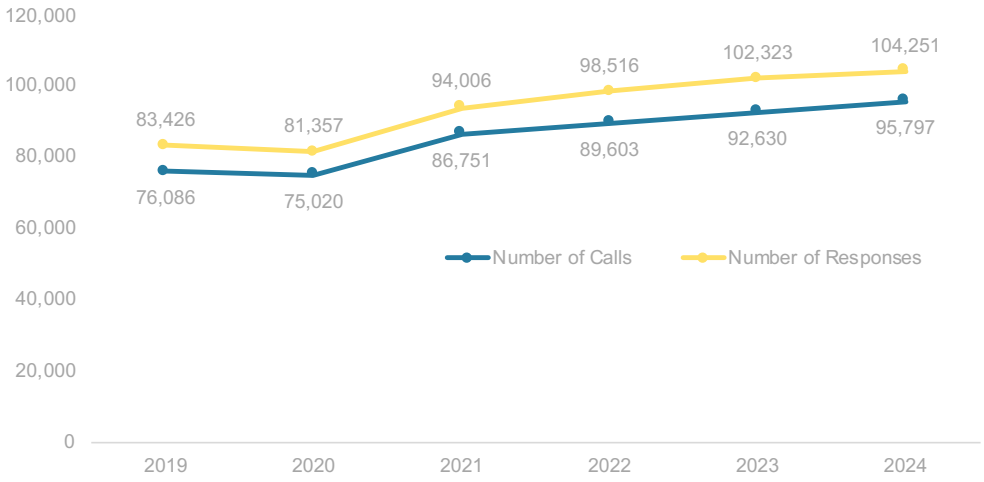


Data Source: Niagara Emergency Medical Services, 2025

EMS USAGE IN NIAGARA

Data Source:
Niagara Emergency Medical Services, 2025

Note:
The number of calls includes all phone interactions, regardless of whether a unit was assigned; Number of responses includes the number units that responded to all calls; Multi-patient calls with one unit responding are counted as a single response.



The number of both calls and responses continues to increase each year:

- There is a 3.4 per cent increase or 3,167 more calls to EMS from 2023 to 2024
- There is a 1.9 per cent increase or 1,928 more EMS responses from 2023 to 2024

Patterns over time show a sharper increase from 2020 to 2021 for both calls and responses

EMS RESPONSE TIMES

Data Source:
Government of Ontario; Response times in Ontario, 2024

Note:
Mean for Ontario response times were calculated by taking the mean response times from each of the ambulance service coverage areas rather than the mean from all coverage areas, as such interpret results with caution

6:41 MINS

Average of reported Land Ambulance Service average response times in Niagara (2022)

9:38 MINS

Average of reported Land Ambulance Service average response times in Ontario (2022)

In 2022, the average time for Niagara EMS was 6:41 mins; this is lower compared to the average of all other reported Land Ambulance Service average response times in the province (9:38 mins).

- Comparisons to other geographies should be interpreted with caution, given that different areas have different geographies and/or health concerns, it can explain some of the variation in results

Priority 1 calls have the lowest percentage of achieving its target of an eight-minute response time; however, Priority 5 calls have the highest percentage of achieving its target of a 120-minute response time.

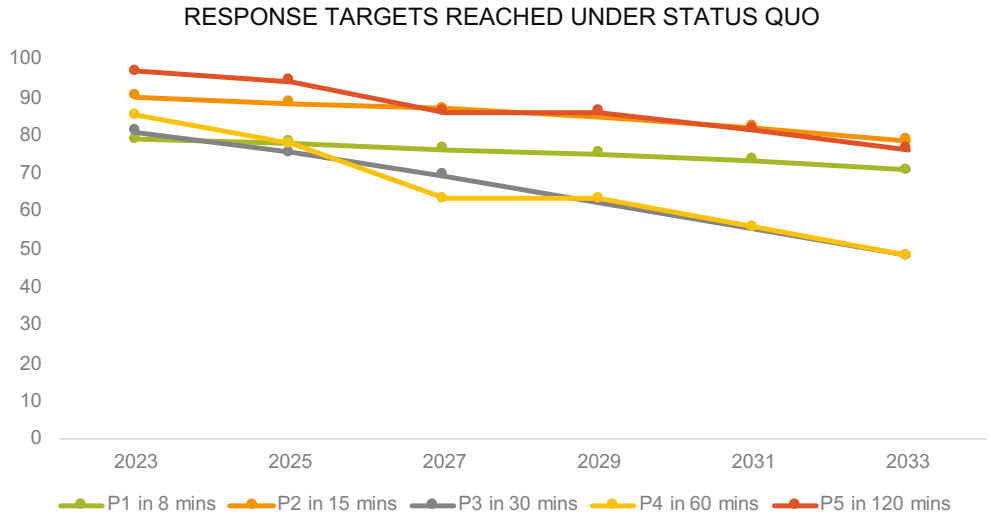
Ambulance utilization reaches its highest level which is under 50 per cent from around 11:00 until 15:00. Afterwards, utilization starts to reduce until a secondary peak of approximately 45 per cent between 20:00 and 22:00.

FORECASTING EMS UTILIZATION

Consultants completed an analysis to understand current and past EMS service utilization. This information informs investments required to operate in a more effective manner and help achieve desired outcomes.

Data Source:
Operational Research in Health Limited, 2024; Niagara Emergency Medical Services, 2024

Note:
Priority 1 to 2 response time performance is measured from the time the first vehicle is assigned, Priority 3 to 5 is measured from the time of the call



KEY OBSERVATIONS

If EMS continues to operate as it currently does, P1 8-minute response performance for Niagara Region will fall to 70.8 per cent in 2033, which is well below its target of 80.0 per cent. Moreover, P2 will fall to 78.6 per cent in 2033. The lower priority categories fall even further.

The difference in response times meeting their target means that an additional 1,456 P1 calls will miss their target in 2033; 20,254 calls altogether will miss their target in 2033.

Age and service demand are correlated, meaning older age groups are more likely to require calls for EMS. Given that the population is getting older and higher service utilization is likely, demand for EMS will continue to increase into 2033; demand is expected to increase 40 per cent from 2023 to 2033.

SO WHAT?

The indicators presented are critical indicators for health system performance and emergency preparedness. Rising EMS call volumes, shifting patient needs, and forecasted declines in response-time performance illustrate how pressures are evolving as the population grows and ages. These patterns highlight where urgent care demands are concentrated and how they may change over time.

Understanding EMS utilization is also important for interpreting pressures in other parts of the system. Increased call volumes contribute to higher numbers of emergency department arrivals and place added strain on hospital follow and inpatient capacity. As demand continues to rise, maintaining timely access to emergency care becomes more challenging.

These trends provide important context for anticipating future pressures across the continuum of care. Future implications for health system capacity are explored in the Insights section.

HOSPITALS

Hospitals provide a broad range of acute and specialized services across Niagara, including emergency and urgent care, inpatient medicine and surgery, maternal and newborn care, mental health and addictions services, diagnostics, and rehabilitation. These services form the core of the region's healthcare system and respond to both planned and unplanned care needs. Rising demand, driven by an aging population, increasing acuity, and growing complexity, continues to place pressure on hospital resources and service delivery. As a result, hospitals across Niagara and the province are experiencing capacity constraints, including pressures on beds, diagnostics, staffing, and patient flow. These challenges highlight the need for coordinated models of care and strengthened partnerships across the broader health system to support timely access and appropriate use of hospital services.

HOSPITALS BY THE NUMBERS

Among seven facilities within the geography of Niagara, five are operated by Niagara Health, while one is operated by Hamilton Health Sciences Corporation (West Lincoln) and the other by Hotel Dieu Shaver Health and Rehabilitation (St. Catharines). In 2024-25:

- Niagara Health had 89.1 per cent of Niagara ED visits while Hamilton Health Sciences had 10.9 per cent; these are similar to results from 2023-24
- Niagara Health had 92.1 per cent of Niagara hospitalizations while Hamilton Health Sciences had 7.9 per cent; these are like 2023-24 results

Unless noted otherwise, the data below comes from Niagara Health.

3

Hospital sites run by Niagara Health

2

Urgent Care Centres run by Niagara Health

33,453

Day surgery cases

88,937

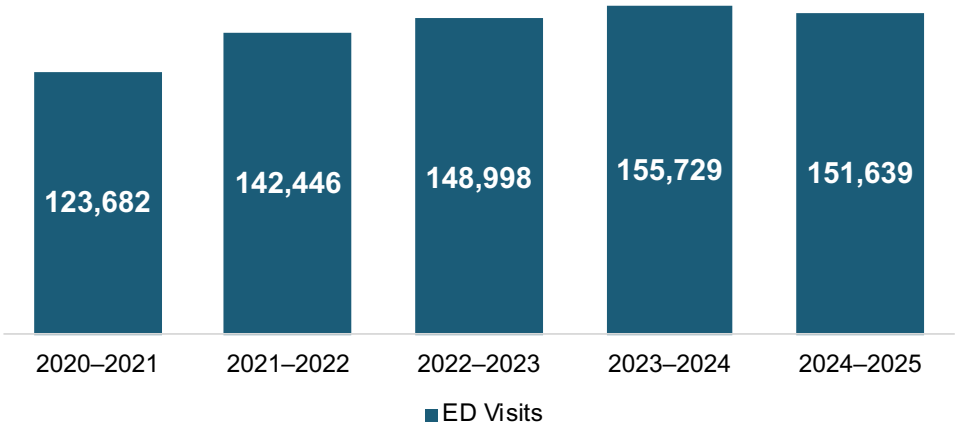
Clinic cases

Data Source:
Niagara Health, 2025

EMERGENCY DEPARTMENT (ED) VOLUME

Data Source:
Niagara Health, 2025

Note:
Dates included are reported by fiscal year.



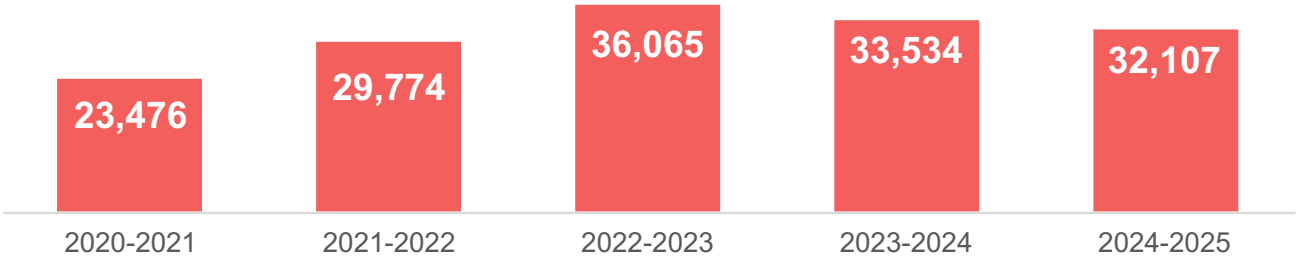
The five-year trend for ED visits showed a peak during the 2023–2024 fiscal year with 155,729 visits, which decreased 2.6 per cent to 151,639 visits in 2024-2025

During 2024-2025, the percentage of ED visits shows that most visits occur at the St. Catharines (46.0 per cent) site, followed by Niagara Falls (32.0 per cent) and Welland (22.0 per cent); these results are consistent over time

There are higher percentages of high acuity visits occurring at the St. Catharines (87.5 per cent) site, followed by the Niagara Falls (84.5 per cent) and Welland (82.9 per cent) sites

Most commons reasons for ED visits:	Most common reasons for admissions:
Digestive system disorders such as gastroenteritis, colitis and/or other unspecified abdominal pain	Normal Newborn (Vaginal)
Skin and breast disorders such as cellulitis, rashes and/or superficial lower body injuries	Chronic Obstructive Pulmonary Disease (COPD)
Respiratory system disorders such as pneumonia and/or dyspnea	Heart Failure (No Angiogram)
Musculoskeletal and connective tissue disorders such as lower back/limb pain, cervicalgia and/or dorsalgia	Vaginal Birth with Anesthetic
Cuts, dislocations, nerve, and soft tissue injuries	Pneumonia (Bacterial)

URGENT CARE CENTRE (UCC) VOLUME



Data Source:
Niagara Health, 2025

Note:
Dates included are reported by fiscal year

The five-year trend for UCC visits had a peak of 36,065 visits during the 2022–2023 fiscal year. This decreased 7.0 per cent to 33,534 visits in 2023-2024.

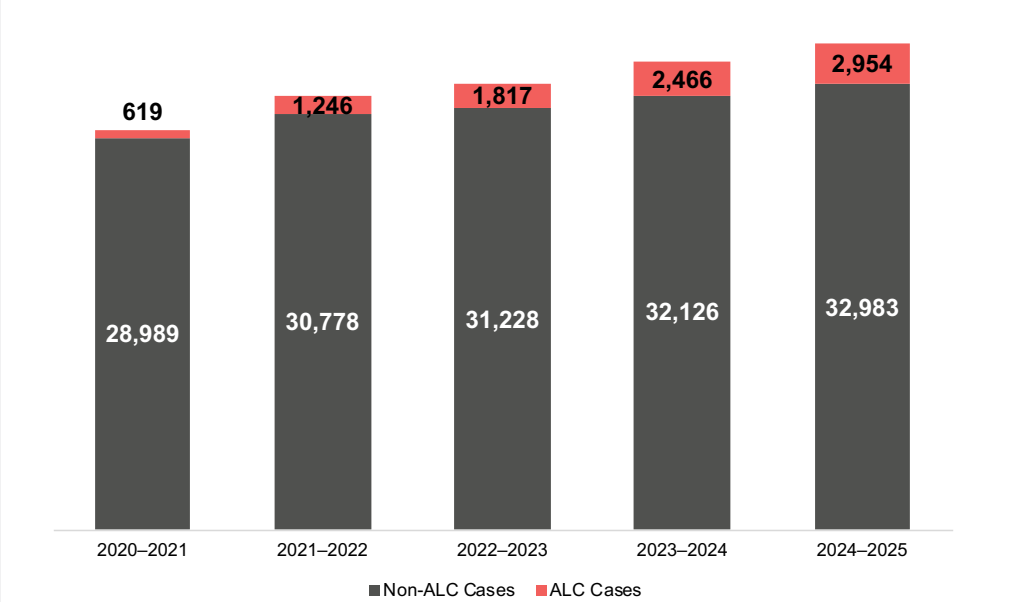
MOST COMMON REASON FOR UCC VISITS

- Acute upper respiratory infection
- Otitis media
- Urinary Tract Infection
- Pneumonia (unspecified)
- Bronchitis

ACUTE INPATIENT CASES AT NIAGARA HEALTH

Data Source:
Niagara Health, 2025

Note:
Dates included are reported by fiscal year. ALC cases (Alternate Level of Care) refer to patients who no longer need the intensity of services provided in an acute care bed but cannot yet be discharged because appropriate care or placement elsewhere is unavailable



KEY OBSERVATIONS

During the 2024-25 fiscal year, there were 35,937 acute discharges; 2,954 or 8.2 per cent of which are Alternate Level of Care (ALC) discharges. Over the last five years, the percentage of ALC discharges has increased by 6.1 per cent.

Average length of stay appears to be more stable; however, changes that seem subtle can have larger effects. In 2024-25, the average ALC length of stay increased by 0.6 days. Although the observed difference is small, this equates to 8,791 days or 24 beds. ALC is a symptom of upstream delays. These waits may be attributable to waits for home and community support.

HOSPITAL - PERSONS EXPERIENCING HOMELESSNESS

5,097

Emergency department (ED) registrations among individuals who identify as homeless

330

Inpatient discharges among individuals who identify as homeless

During the 2024–25 fiscal year, there were 5,097 ED visits by individuals experiencing homelessness — a 51.7 per cent increase compared to 2023–24. Recent trends indicate a continued rise in ED presentations among this population

During the 2024–25 fiscal year, there were 330 inpatient discharges involving individuals experiencing homelessness – a 21.3 per cent increase compared to 2023–24. Recent trends indicate that inpatient discharges among this population continue to rise.

- In 2024–25, inpatient discharges among individuals experiencing homelessness reveal the most common reasons for visits) include:
    - Cellulitis
    - Bacterial pneumonia
    - Diabetes
    - Viral/unspecified pneumonia
    - COPD
    - Substance abuse

Data Source:
National Ambulatory Care Reporting System (NACRS), 2025; Discharge Abstract Database (DAD), 2025; Niagara Health, 2025

DEMAND FOR HOSPITAL SERVICES FOR KEY CONDITIONS

This section summarized hospital demand related to Maternal and Newborn Services, Cancer, Mental Health and major Chronic Diseases. These indicators help contextualize how acute care utilization reflects the population health patterns described earlier in the report.

Maternal and Newborn Services – Birth Volumes:

- 2020-21: 3,382
- 2021-22: 3,618
- 2022-23: 3,332
- 2023-24: 3,335
- 2024-25: 3,495

Birth volumes remain stable over time, indicating sustained demand for hospital-based maternal and newborn services despite broader demographic trends; the higher volume observed in 2021-22 reflects pandemic-related effects. There was a 4.8% increase in births from 2023-24 to 2024-25.

Top ED Visits for Chronic Conditions (Excl. Mental Health) for the 2024-25 FY include:

- Arthritis → 6,522 visits or 2.2 per cent increase from last year
- COPD → 2,807 visits or 8.3 per cent increase from last year
- Congestive heart failure → 1,283 visits or 15.5% decrease from last year
- Hypertension → 1,359 visits or 9.1per cent decrease from last year
- Diabetes → 1,175 visits or 1.3% decrease from last year

Consistent with population health trends, COPD and arthritis represent significant drivers of ED use.

Top Inpatient Admissions for Chronic Conditions for the 2024-25 FY include:

- Cancer → 1,268 admissions or 7.0 per cent increase from last year
- COPD → 1,219 admissions or 17.1 per cent increase from last year
- Ischemic Heart Disease → 908 admissions or 7.3 per cent decrease from last year
- Stroke → 756 admissions or 12.2 per cent increase from last year
- Diabetes → 620 admissions or 1.4 per cent decrease from last year

Inpatient utilization mirrors chronic disease prevalence patterns, especially COPD, cancer and stroke.

Mental Health ED Visits for the 2024-25 FY include:

- Neurotic Disorder → 2,407 visits or 3.1 per cent increase from last year
- Mood Disorder → 1,184 visits or 7.2 per cent decrease from last year
- Schizophrenia → 873 visits or 3.5 per cent decrease from last year
- Personality Disorder → 388 visits or 12.5 per cent increase from last year
- Other MH Disorder → 196 visits or 21.3 per cent decrease from last year
- Dementia → 184 visits or 17.2 per cent increase from last year

ED demand for mental health reflects population-level needs, including increases among older adults (dementia).

VISITS TO THE ED THAT COULD BE MANAGED BY PRIMARY CARE

Visits to the ED that could be managed by:	Site	2022-23 Risk-adjusted per cent	2023-24 Risk-adjusted per cent
Primary care (PCSC)	**West Region**	13.4	13.1
	Niagara	7.2	7.1
	Niagara Falls	8.1	7.8
	St. Catharines	6.2	6.1
	Welland	8.0	8.0
Virtual primary care (V-PCSC)	**West Region**	8.6	8.3
	Niagara	4.7	4.6
	Niagara Falls	5.4	5.1
	St. Catharines	4.0	4.0
	Welland	5.3	5.2

Data Source:
National Ambulatory Care Reporting System (NACRS), 2022–2023 and 2023–2024, Canadian Institute for Health Information, 2024

Note:
CIHI defines ED visits that could be managed in primary care as low-acuity cases, where the patient's condition does not require hospital-level resources. These visits often involve common, non-urgent issues (like minor infections or prescription renewals) that could reasonably be treated in a family doctor's office, walk-in clinic, or through virtual care.

KEY OBSERVATIONS

The risk-adjusted per cent for Niagara hospitals is significantly lower across all categories presented above. In other words, compared to other hospitals in the West Region, Niagara hospitals are less likely to see patients in the ED for issues that could have been managed in primary care.

CAPACITY

For the purposes of this report, hospital capacity is presented using the four components of the definition: Stuff, Space, Staff and Systems.

STUFF:
BEDS, EQUIPMENT AND SPECIALIZED RESOURCES

863

All Niagara Health sites

629

Acute beds (72.9 per cent of beds)

55

West Lincoln Hospital inpatient beds

134

Hotel Dieu Shaver inpatient beds (with an approved expansion to 196 beds)

475

South Niagara Hospital (expanding regional capacity by adding 156 new beds)

DIAGNOSTIC IMAGING

Niagara Health provides diagnostic imaging services across the continuum of care, including medical imaging, cardio diagnostics, and interventional radiology. Diagnostic Imaging also supports population health through provincially mandated screening programs, including:

- Ontario Breast Screening Program
- Aortic Aneurysm Screening Program
- Lung Cancer Screening Program (launching April 2026)

Niagara Health is the sole provider of advanced diagnostic imaging services in the Niagara region. As such, Diagnostic Imaging supports outpatients, inpatients, emergency departments, and urgent care centres. Significant operational effort is required to prioritize urgent and time-sensitive imaging for emergency and inpatient care, while maintaining access for outpatient and screening programs.

Niagara Health currently has:

- Three MRI Scanners (1.5T and 3T)
- Five Diagnostic CT Scanners
- Three Nuclear Medicine Labs
- Four Fluoroscopy Rooms
- One Angiography Suite
- Ultrasound, X-ray, Cardiac Imaging

DIAGNOSTIC IMAGING VOLUMES (2024-25)

	Outpatient volume	Inpatient volume	Total Volume
Medical Imaging	**293,825**	**91,553**	**385,378**
Cardio Diagnostics	**68,809**	**51,356**	**120,165**

There has been an evolution in healthcare in which advances in diagnosis, treatment, management, and surveillance of health conditions are increasing reliance on diagnostic imaging. Medical imaging volumes have grown between 4.5 per cent and 8 per cent annually, with the most significant increases observed in CT and MRI utilization. Increasing patient complexity, along with cancer being managed as a chronic condition, contributes to patients requiring multiple imaging examinations over the course of care, further intensifying demand on diagnostic imaging resources. Opportunities exist to further strengthen clinical appropriateness and utilization guidance to support the appropriate use of diagnostic imaging and manage demand for imaging services.

SPACE: INFRASTRUCTURE

Niagara Health (NH) delivers acute care through three main hospital sites located in the region's most populous urban centres: St. Catharines, Niagara Falls and Welland. These sites provide the majority of emergency, inpatient, surgical, diagnostic and specialty services for the region. Two Urgent Care Centres in Fort Erie and Port Colborne support lower-acuity and ambulatory needs. Hospital infrastructure varies in age and configuration across sites, influencing patient flow, service distribution, and operational flexibility. The South Niagara Hospital will add modern infrastructure and expanded capacity, supporting a full range of acute care services.

Modernizing and consolidating infrastructure enhances NH's ability to manage growing and increasingly complex demand. Infrastructure renewal supports consistent care pathways and operational efficiency but requires complementary investments in staffing and system integration to optimize flow.

STAFF:
TRAINED PERSONNEL

Niagara Health employs over 7,800 staff, physicians, volunteers, and patient partners across its sites, forming a multidisciplinary workforce essential to acute and specialty care.

NURSING AND ALLIED HEALTH

- Nursing Workforce: 2,852
- Allied Health Professionals: 995

ADMINISTRATION AND SUPPORT

- Non-Union Staff: 671
- Service Staff: 1,928

PHYSICIANS:

As of December 1, 2025, NH has approximately 720 credentialed physicians supporting emergency, inpatient, surgical, diagnostic, outpatient, and specialty programs.

There are key physician shortages in priority areas, including:

- General Internal Medicine
- Emergency Medicine
- Mental Health & Addictions
- Surgical Assistants
- Cardiology

The physician workforce plays a central role in the functioning of NH's acute, emergency, and specialty programs. Shortages across medicine, emergency, mental health, and surgical supports place pressure on clinical operations, affecting ED flow and inpatient coverage.

SYSTEMS:
POLICIES AND PROCEDURES

HOSPITAL INFORMATION SYSTEM (HIS)

Niagara Health and Hotel Dieu Shaver implemented a modern HIS in 2025 that will support capacity by:

- Improving patient flow through real-time access to information
- Reducing delays and duplication of tests and documentation
- Enhancing coordination across units and sites
- Strengthening operational planning through better data availability

REGIONAL SERVICE MODEL

- NH is progressing toward a regional service model that will eventually anchor acute and specialized services across St. Catharines, Niagara Falls, and the future South Niagara Hospital.
- The three-site model is intended to optimize staffing, improve outcomes and delivery of consistent service models.
- Full implementation of this model has not yet occurred, and existing service structures continue to shape current capacity.

CENTRES OF EXCELLENCE

- Designated Centres of Excellence in Stroke, Wellness in Aging, and Complex Care are being developed as part of the future South Niagara Hospital. These programs will consolidate expertise and standardize clinical practice across the system.
- As planning progresses, their impact on current capacity is limited, but they represent an important future lever for improving quality, coordination, and system-wide flow

From a capacity perspective, the HIS provides the most immediate impact by reducing inefficiencies and improving coordination across sites. The regional service model and Centres of Excellence are still in development, but they represent improvements that improve outcomes. Continued alignment with community and post-acute partners remains essential to addressing system-wide pressures.

SO WHAT?

The hospital data highlights a system experiencing sustained pressure across emergency and inpatient services, with rising acuity, increased complexity, and growing utilization by individuals with significant medical and social needs. Chronic disease-related activity in both the Emergency Department (ED) and inpatient settings – particularly for COPD, cancer, arthritis and stroke – reinforces earlier population health findings showing an aging population and increasing burden of chronic disease.

Alternate Levels of Care pressures continue to limit available bed capacity, while diagnostic and physician resource constraints affect flow and timely access to care. Lower-acuity conditions continue to be managed through urgent care centres in the current state, but EDs remain the primary point of access for many high-need populations, particularly individuals experiencing homelessness.

Emerging capacity supports—such as the modern HIS, the planned regional service model, Centres of Excellence, and future expansion through the South Niagara Hospital—are expected to strengthen coordination and service distribution over time, although they have not yet influenced current operational pressures.

Overall, the hospital system is managing increasing complexity within constrained bed, diagnostic, and physician resources. Strengthening transitions of care, enhancing integration with community and primary care partners and addressing identified capacity constraints are essential to sustaining performance and preparing for anticipated future demand.

HOSPICE CARE

As Niagara's population grows older, more residents are living longer while facing serious health challenges such as heart disease, and different forms of cancer. The demand for hospice and palliative care continues to rise, yet the region lacks the hospice beds and community-based services to meet current and anticipated needs. Access to high-quality end-of-life care remains uneven, and many individuals and families lack the supports required to manage advanced illness with dignity.

Beyond residential hospice beds, palliative care services are delivered across hospitals, home care, long-term care, and community settings. However, consistent, system-level data on palliative care capacity, workforce, and service volumes across Niagara are limited. As a result, this assessment focuses on hospice beds as the most reliable indicator of end-of-life care capacity, while recognizing that broader palliative services represent an important area for future data development and planning.

HOSPICE BY THE NUMBERS

There are currently two hospice palliative care centres operational in Niagara; located in St. Catharines and Welland. A third location in Fort Erie plans to be operational in 2026. There are 10 beds available at the St. Catharines location and 10 at the Welland location. Fort Erie plans to have 10 beds which means Niagara region will have 30 beds altogether. External analysis from the Auditor General of Ontario recommends 31 to 45 beds to meet community needs.

Home care is adjacent to hospice care where some individuals can receive home care prior to entering hospice. During the 2023-24 fiscal year, 22,123 clients received home care services; the number of clients has been consistent over time. Common chronic diseases amongst home care clients include arthritis, stroke and ischemic heart disease.

SO WHAT?

Niagara is facing a serious gap in hospice and palliative care. With only 20 hospice beds in Niagara, the region falls far below provincial standards, and referrals continue to rise. It is recommended that Niagara should have 31 to 45 beds to meet community needs, underscoring the urgent need to expand services.

Insufficient hospice availability can lead to avoidable Emergency Department (ED) use, longer hospital stays, and increased pressure on inpatient units. Understanding this gap helps contextualize both hospital Alternate Level of Care pressures and the rising demand for end-of-life services across the system.

LONG-TERM CARE HOMES

Long-term care homes play a vital role in supporting the health and well-being of older adults and individuals with complex care needs who require 24-hour support. These settings are essential components of the broader health system, providing not only medical care but also social and emotional support. However, long-term care homes continue to face significant challenges, including staffing shortages, aging infrastructure, and increasing demand driven by demographic shifts. The COVID-19 pandemic further highlighted vulnerabilities within the sector, emphasizing the need for strengthened infection control, resident-centered care models, and system integration.

LONG-TERM CARE HOMES BY THE NUMBERS

30
Long-term care homes in Niagara

3,821
Number of long-term care beds in Niagara

6,154
Number of applications on waiting lists

Data Source:
Niagara Navigator, 2025; Ontario, 2025

The number of long-term care facilities ranges from one in Port Colborne to nine in St. Catharines. Welland and Niagara Falls have five and six facilities respectively.

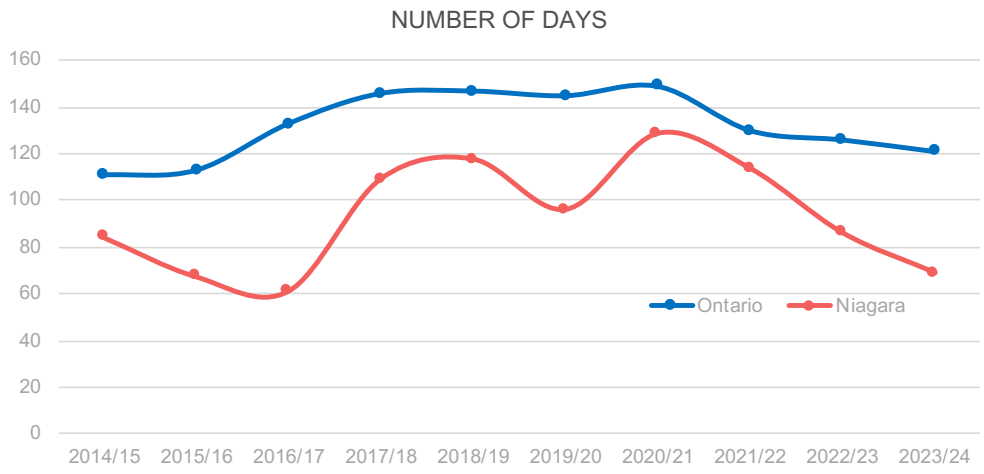
St. Catharines has the highest number (2,482) of applications on waiting lists.

See Appendix B.

COMPARED TO ONTARIO, NIAGARA HAS LOWER MEDIAN WAIT TIMES (IN DAYS) FOR LONG-TERM CARE HOMES

Data Source:
Ministry of Health, 2025

Note:
Median for Niagara was calculated by taking the median number of days from each facility rather than the median from all facilities as such interpret results with caution; Includes individuals placed from hospitals or placed from the community; Excludes residents who were transferred from another long-term care home



KEY OBSERVATIONS

During the 2023-24 fiscal year, individuals applying to Niagara Long-Term Care homes had a median wait time of 69 days before being accepted compared to 121 days for the rest of the province.

Patterns are also trending downward, indicating that Niagara residents spend less time waiting compared to previous years.

SO WHAT?

With Niagara's population continuing to age, demand for long-term care will intensify over the coming years. Although wait times are shorter than the provincial average, the volume of applications and the scale of unmet need indicate growing pressure on the sector. Long-term care capacity directly affects hospital Alternate Levels of Care rates, Emergency Department utilization among older adults, and system flow. Understanding these patterns is essential for anticipating future pressures on acute care and home and community services.

OTHER SERVICES WITHIN NIAGARA

MENTAL HEALTH SERVICES

Data Source:
Canadian Mental Health Association Niagara, 2025

Mental health services are a critical component of the region's health system, addressing growing needs for accessible care. These services encompass a wide range of supports, including counseling, crisis intervention, community-based programs and inpatient care. Challenges remain in meeting demand, reducing wait times, and ensuring equitable access across urban and rural areas and for vulnerable groups. Strengthening mental health services is essential for improving overall population health and reducing the burden of untreated mental illness.

9,070
Individuals served by the Canadian Mental Health Association (CMHA)

7,850
Brief services were provided

1,220
Long-term services were provided

7,826
Additional telephone interactions

The number of individuals served by CMHA has steadily increased each year, demonstrating the need for increased mental health services.

The number of individuals using long-term services decreased from 1,304 in 2023-24 to 1,220 in 2024-25, use for brief services increased.

The most common services used include:

- Information and referral
- Crisis Outreach & Support Team (COAST)
- Urgent Support
- Mobile Crisis Rapid Response Team (MCRRT)

SO WHAT?

Increasing demand for mental health services aligns with patterns observed in hospital Emergency Department (ED) data and broader population health trends. Shifts toward brief services may reflect capacity limitations or changing service needs. These trends highlight the importance of community-based mental health support in reducing avoidable ED visits and improving system flow. Delivering effective community-based mental health care relies on a multidisciplinary workforce, including social workers, mental health nurses, counsellors, peer support workers, crisis outreach teams, and case managers who can provide timely, coordinated, and culturally responsive care across settings.

HOMELESS SHELTERS

Shelters play an important emergency role for individuals experiencing homelessness; however, they are not a long-term solution. The growing rate of chronic homelessness underscores the need for permanent, supportive housing options that integrate health and social services.

SHELTERS BY THE NUMBERS

10
Shelter locations in Niagara

307
Number of spots available in shelters

96.9%
Average occupancy in 2025 (as of September 2025)

Data Source:
Niagara Region, 2025

Note:
Data only includes shelters that are funded by Niagara Region. Data for other shelters, such as Women's shelters are not included.

[17] Chronic homelessness is defined as being homeless for 180 days in the past year or 550 days in the past three years

As of September 2025, Niagara's average occupancy system wide has been 96.9 per cent with an average length of stay of approximately 23 days. Only 13.9 per cent of shelter exits result in clients securing some form of housing, which has the lowest rate in the past five years, highlighting the shortage of housing options.

Total homelessness has increased slightly over the past four years, however there is now more chronic homelessness[17] than there is non-chronic. Some patterns in shelter usage can be attributed to availability of new shelter spaces; that is, new shelters were opened in October 2023 and January 2025 which may cause spikes. Assuming intakes maintain their current pace, data suggests there could be 6,187 intakes by the end of 2025. This would be the highest number of intakes within the last five years.

DEMOGRAPHICS OF INDIVIDUALS USING SHELTER SERVICES

Data Source:
Niagara Region, 2024

65.4%
Between the ages of 26-54

83.0%
Report being Canadian citizens

60.3%
Identify as male

8.9%
Identify as Indigenous/ First Nations/Metis

6.1%
Identify as a member of the LGBTQ2S+ community

Demographics of those who use shelters are generally consistent over time. However, challenges can arise as more attention is placed on the senior population, given the population continues to get older (particularly chronic seniors).

According to 2024 Point-in-Time Count data, a cross-sectional survey of those experiencing homelessness:

- 78.9 per cent of respondents reported Ontario Works (OW) or Ontario Disability Support Program (ODSP) as their main source of income
- Greater than 70 per cent of respondents reported a mental health issue
- 54.1 per cent reported issues with substance use
- 38.4 per cent reported experiencing homelessness for the first time as a child or youth

SUPPORTIVE HOUSING

Supportive housing combines affordability (rent support) with suitable services (health and social services). Factors considered for supportive housing include the location of units, building diversity, accessibility, and more. It also ensures culturally safe and appropriate supports tailored to individual needs. Supportive housing can be categorized into two levels.

1. **Supportive Housing** – requires moderate support needs/case management
2. **Highly Supportive Housing** – Complex and persistent needs such as chronic health conditions or severe mental health which requires intensive case management

SUPPORTIVE HOUSE BY THE NUMBERS

427

Units/caseload space for supportive housing

0

Units/caseload space for highly supportive housing

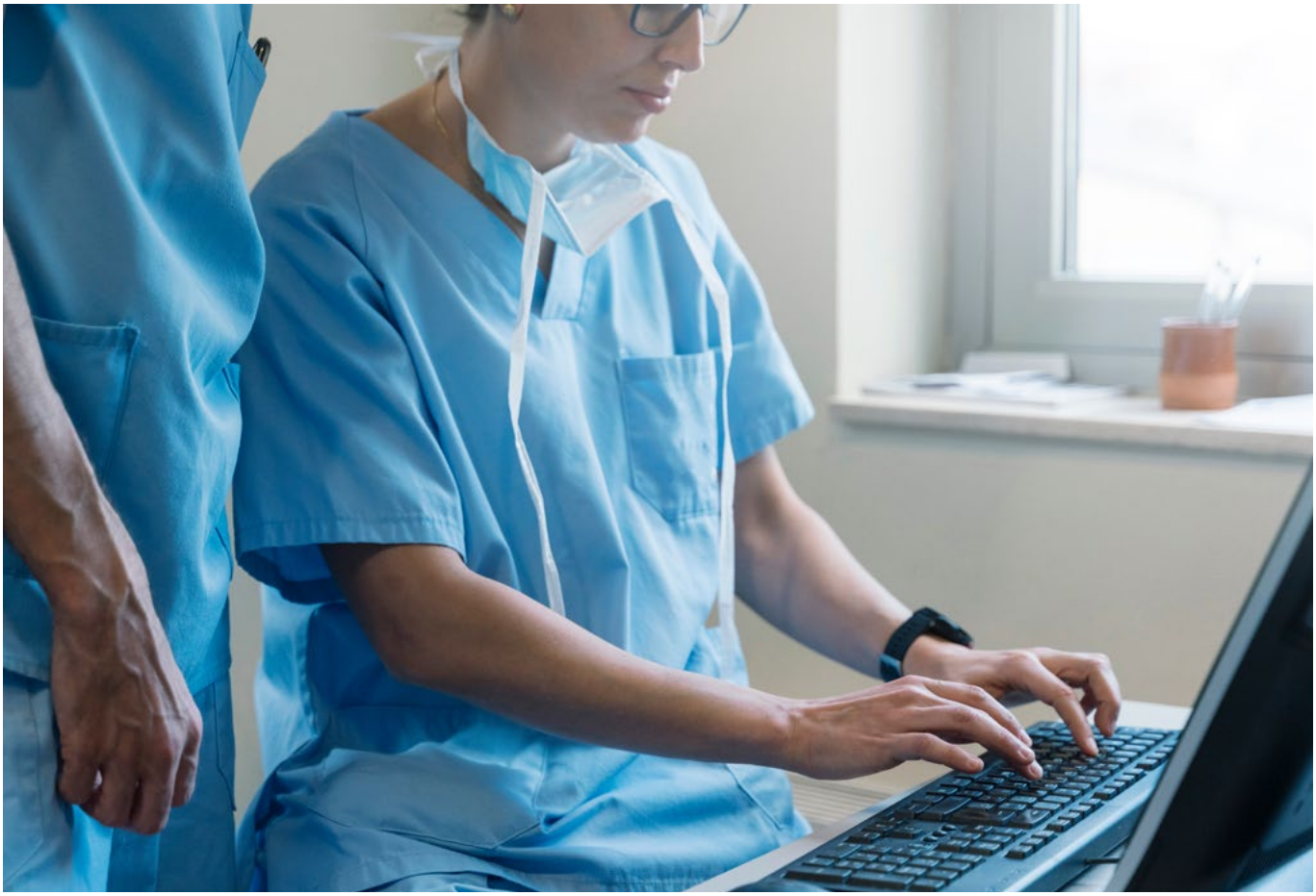
Data Source:
Niagara Region, 2025

The 427 spaces for supportive housing are broken down further below based on the types of programs and the additional services they offer: 272 - Housing First; 115 - Transitional Housing; 15 - Bridge Housing and 25 - Permanent Supportive Housing.

These programs generally work on building life skills or addressing mental health/trauma for clients.

Forecasting shows that over the next 10 years, there will need to be additional caseload increases for the following: 380 supportive housing caseload spaces: 290 needed now; 90 in the next 10 years; 565 highly supportive housing units: 430 needed now; 135 in the next 10 years.

Shortages in supportive housing lead individuals to be more reliant on shelters as a result.



SO WHAT?

Shelter data indicate rising demand, persistently high occupancy, and an increasing proportion of individuals experiencing chronic homelessness. With only 13.9 per cent of shelter exits leading to housing, the system is functioning largely as short-term crisis response rather than a pathway to stability. At the same time, supportive housing capacity is insufficient to meet current or projected needs, particularly for individuals with complex health, mental health, or substance-use challenges.

These patterns have direct implications for the broader health system. Individuals without stable housing face higher rates of chronic illness, infectious disease, and mental-health concerns, and often rely on Emergency Departments for episodic or crisis-driven care. Insufficient supportive housing contributes to repeated shelter use, preventable health deterioration, and increased downstream pressure on hospitals and community services.

Strengthening supportive housing capacity—and improving pathways from shelters into long-term, sustainable housing—is essential to improving health outcomes and reducing avoidable strain across the healthcare system.

INSIGHT

HOW DO SYSTEM RESOURCES AND UTILIZATION PATTERNS IMPACT HEALTH SYSTEM CAPACITY?

STUFF
RESOURCES, DIAGNOSTICS, SUPPLIES, EQUIPMENT

CURRENT STATE:

- Hospitals face high and rising diagnostic demand for chronic disease, acute care and cancer-related services
- Emergency Medical Services (EMS) fleet and equipment utilization intensifies with rising call complexity and volumes
- Long-Term Care (LTC), home care and supportive housing require specialized equipment to manage increasing clinical needs outside of hospital settings
- Mental health and substance-use services require consistent resources for crisis response and harm reduction

IMPLICATIONS:

- Resource availability must align with where care is delivered—or should be delivered—to reduce avoidable hospital use
- Insufficient community-based equipment (mobility aids, home medical supplies, supportive housing resources) drives higher reliance on hospital services
- Growing diagnostic demand underscores the need for capacity in imaging, laboratory services, and clinical monitoring tools
- EMS and acute care equipment pressures reflect increasing medical complexity and volume trends, with implications for reliability and response readiness

SPACE
INFRASTRUCTURE AND SERVICE DISTRIBUTION

CURRENT STATE:

- Primary care infrastructure is strained by high unattachment and uneven geographic distribution of providers
- EMS bases and deployment capacity face increasing utilization as call volumes grow annually
- Hospital sites operate at high volumes with sustained Emergency Department (ED) pressure, rising acuity and Alternate Level of Care constraints
- LTC and hospice beds are insufficient relative to demographic trends and projected need
- Shelters operate at nearly full occupancy, with rising chronic homelessness and limited discharge pathways

SPACE
INFRASTRUCTURE AND SERVICE DISTRIBUTION
CONTINUED

IMPLICATIONS:

- Infrastructure constraints across primary, emergency, acute, and long-term care are interdependent; shortages downstream (LTC, supportive housing) reduce flow and elevate demand upstream (ED, inpatient units, EMS)
- Geographic variation in population need—especially in areas with high deprivation—requires tailored placement of services and infrastructure
- Future infrastructure expansions (South Niagara Hospital, hospice development) will only improve capacity if paired with parallel staffing, system flow, and community capacity improvements
- Shelters operate at nearly full occupancy, with rising chronic homelessness and limited discharge pathways

STAFF
COORDINATION AND PLANNING

CURRENT STATE:

- Primary care faces retirement risks and recruitment challenges, affecting continuity and access
- Hospitals experience pressure in key physician specialties (general internal medicine, emergency, mental health, surgical assistants) and high nursing and allied health demand
- EMS staffing must scale with forecasted increases in call volume and medical complexity
- LTC, home care and supportive housing face chronic staffing shortages, limiting discharge options and transitional care
- Mental health service demand continues to grow, requiring sustained workforce capacity
- Hospice and palliative care services also face workforce pressures, as existing staffing levels are insufficient to meet current and projected demand

IMPLICATIONS:

- Workforce limitations—in primary care, acute care, community care, and EMS—are a critical bottleneck for system capacity
- Physician shortages in high demand areas reduce ED flow, inpatient coverage, and diagnostic throughput, limiting the system's ability to respond to rising acuity and complexity
- Staffing shortages reduce system elasticity, lengthen wait times, and contribute to ALC growth, ED boarding and EMS offload delays
- Workforce pressures across sectors compound one another; gaps in community staffing directly increase acute-care demand
- Sustained population aging and chronic disease prevalence will intensify long-term workforce needs across clinical and support roles

SYSTEM COORDINATION, FLOW, PLANNING AND INTEGRATION

CURRENT STATE:

- High unattachment to primary care contributes to avoidable ED visits and fragmented care
- Hospital flow challenges (such as ALC growth, ED congestion) reflect misalignment between acuity, capacity, and community-based options
- EMS offload delays reduce ambulance availability during peak periods
- LTC wait lists, shelter occupancy, and limited supportive housing capacity restrict transitions of care
- Mental health and substance-use patterns reveal gaps in coordinated community-acute pathways

IMPLICATIONS:

- System capacity challenges often stem from coordination gaps rather than isolated resource shortages
- Flow between sectors—primary care → hospital → community supports—is fragile and highly sensitive to downstream constraints
- Integration between hospitals, EMS, primary care, and social services is central to maintaining timely access and system performance
- Homelessness and housing instability significantly influence system demand patterns and require coordinated intersectoral planning
- Supportive housing gaps require explicit system-level planning, as insufficient capacity directly prolongs hospital stays, increases ED utilization, and impedes effective care transitions

WORKFORCE PLANNING

Workforce is one of the most critical determinants of health system capacity. Pressures identified throughout this report – rising acuity in hospitals, persistent primary care unattachment, increasing EMS utilization, significant Long-Term Care demand, chronic homelessness, and growing mental-health needs – are all closely linked to health human resources. Workforce planning must therefore support service delivery across the entire continuum of care: acute, primary, community, long-term care, mental health, EMS and supportive housing.

A sustainable, well-distributed workforce is essential to maintaining timely access, service stability and the system's ability to respond to population health needs. As Niagara's demographic profile shifts and health needs become more complex, coordinated health human resources planning becomes increasingly important.

> At its core, workforce planning is about having the right people with the right skills in the right roles, not just for today but for what lies ahead. It's a balancing act that combines data, foresight, and strategy, making it a key pillar of effective human resource management. This process typically starts with forecasting labor demand and analyzing the capabilities of the current workforce. By identifying skills gaps, organizations can create targeted strategies to bridge them—whether through recruitment, upskilling, or succession planning.[1]

While health workforce data exists locally within each organization, it is very challenging to obtain, extract, clean, and analyze comparable data from across each organization to make assessments. Previous attempts to capture this type of aggregate information through a survey were challenging, with poor response rates and incomplete data. Therefore, the project team obtained data via Lightcast[18]— an American company that uses publicly accessible data from Statistics Canada for its Canadian labour market intelligence, incorporating Statistics Canada sources like the Census, Survey of Employment, Payroll, and Hours (SEPH), and the Labour Force Survey (LFS). Lightcast provides its labour market data through software platforms and users (such as Niagara College) pay a yearly subscription to access and download the data. Lightcast data's strengths include granular, real-time job market insights, a skills-based approach for understanding career paths, and the ability to integrate with other data sources. Limitations include potential inaccuracies like outdated or duplicate job postings, overrepresentation of jobs with high turnover, and data that may be a few years out of date, depending on the report.[19]

The project team extracted Niagara specific data from the Lightcast job postings data section to provide insights on current and predicted labour market needs.

- Occupation Overviews are modelled from Statistics Canada sources
- Job Posting Analytics reports use real-time scraped data enriched and standardized by Lightcast

Top posting sources include: indeed.com, jobbank.gc.ca, workopolis.com, localwork.ca, jobshark.com, jobserve.com, glassdoor.ca, myworkdayjobs.com, adp.com, jobs.ca, simplyhired.ca, and taleo.net.

The project team selected over 30 relevant health occupations (see Appendix B) defined by the National Occupation Classification (NOC)[20] coding system.

[18] Lightcast | The Standard for Labor Market Intelligence

[19] Lightcast, ND, https://kb.lightcast.io/en/articles/8736065-data-real-time-jobs-postings-market-representation

[20] National Occupational Classification - Canada.ca

FINDINGS

UNIQUE POSTING RESULTS

Unique postings	How many employers had posted a role between 2020 to 2025

Highest posted positions based on distinct job advertisements in Niagara between 2020 and 2025:

1. Registered Nurses/registered Psychiatric nurses
2. Nurse Aides, Orderlies and Patient Service Associated (such as Personal Support Workers, Dietary Aides)
3. Managers in Healthcare (any generic health manager position posted
4. Dental Assistants and Dental Laboratory Assistants
5. Pharmacy Technical Assistants and Pharmacy Assistants

These patterns reflect the high turnover and persistent workforce demand in nursing, support services and primary care-adjacent roles.

UNIQUE POSTING RESULTS

Posting Intensity	How many times a role was posted before it was filled (higher numbers equate to more difficulty in hiring for that particular role)

The posting intensity is referred to as: the ratio of total to unique (deduplicated) job postings, which indicates the effort an employer is putting into hiring for a specific role. A higher ratio suggests that the employer is posting the same job many times, possibly because they are urgently trying to fill it or having difficulty finding a candidate.

In Niagara, job categories with the highest posting intensity score are:

1. Medical Sonographers
2. Physiotherapists & Medical Radiation Therapists
3. Dental Hygienists and Therapists
4. Audiologists and Speech and Language Pathologists
5. Occupational Therapists & Practical Nurses

This indicates recruitment challenges for specialized diagnostic, therapeutic, and rehabilitation professions – roles that are essential for chronic disease management, aging-in-place, and post-acute recovery.

TOP COMPANIES HIRING:

Top companies hiring	Which employers are hiring

The companies posting/hiring the most from 2020 to 2025 were:

1. Niagara Health
2. Shoppers Drug Mart
3. Dental Organizations
4. Other health systems outside of Niagara (such as Bayshore, Hamilton Health Sciences)

PER CENT CHANGE IN HIRING NIAGARA (2015 TO 2030)

Per cent change in hiring Niagara (2015 to 2030)	Predicted trends in hiring to 2030 (based on multiple data sources)

This measure is distinct from "job openings", which are an estimate of total demand (including replacement needs for workers who retire or change careers) and these per cent change data are generally calculated using a different methodology that combines job growth data with other Statistics Canada data to predict changes in hiring over time.

The jobs with the biggest growth by 2030:

1. Nurse Practitioners
2. Nursing Coordinators and Supervisors
3. Massage Therapists
4. Physiotherapists
5. Occupational Therapists

These trends align with Niagara's aging population and increasing need for rehabilitation, chronic disease support, and substitute decision-making roles (e.g., NPs filling primary care gaps).

LOCAL EDUCATION AND TRAINING PIPELINE

Niagara's post-secondary institutions play a key role in supporting the regional health workforce pipeline. Niagara College, Brock University, the University of Niagara Falls, and partner institutions offer a range of health-related education and training programs, including nursing, practical nursing, personal support work, public health, kinesiology, health sciences, mental health, and allied health disciplines.

While comprehensive data on graduate retention and local workforce entry are limited, the mix of programs aligns closely with projected areas of demand identified in this assessment, including nursing, primary care, mental health, rehabilitation, and community-based care. Strengthening coordination between education providers and system planners represents an opportunity to better align training capacity with long-term workforce needs in Niagara.

SO WHAT?

Labour market and predictive data demonstrate sustained demand for nurses, support workers, health managers, dental professionals, and pharmacy roles—trends consistent with the pressures described throughout this report. Rising utilization, higher acuity, chronic disease prevalence, mental-health complexity, and supportive housing needs all amplify demands on the health workforce.

Projected growth in physiotherapy, occupational therapy, and massage therapy aligns with Niagara's aging population and increased need for mobility, recovery, and post-acute support. Continued high demand for Nurse Practitioners and nursing supervisors reflects the shift toward interdisciplinary care and the need for advanced practice providers to fill gaps in primary and community care.

Local postsecondary institutions (Niagara College, Brock University, McMaster University, and the University of Niagara Falls) produce graduates for many high-demand professions. However, recruitment challenges persist for occupations not trained locally—such as physiotherapists, medical radiation technologists, medical sonographers, and occupational therapists—resulting in chronic vacancies and reliance on external labour markets.

A significant limitation is the absence of standardized workforce data across Niagara's health and social services sectors. Organizational datasets are not comparable, vacancy reporting is inconsistent, and there is no shared Health Human Resource (HHR) surveillance system. This constrains the region's ability to forecast needs, identify shortages, or align educational pipelines with system demand.

Strengthened health human resources planning—including targeted recruitment, retention strategies, educational partnerships, and efforts to address hard-to-fill roles—is essential, but future efforts must also establish a coordinated, multi-sector workforce dataset to support evidence-informed decision-making across the continuum of care. Without improved data infrastructure, workforce gaps will remain reactive rather than proactively managed.

RECOMMENDATIONS

WHAT GAPS IN THE HEALTH SYSTEM EXIST?

Despite ongoing efforts to strengthen health services, notable gaps persist within the local health system that impact access, equity, and overall population health outcomes. These gaps are influenced by demographic change, evolving population health needs, and system-level capacity pressures described throughout this report.

1. INCREASING CHRONIC DISEASE BURDEN

As the population continues to age, the prevalence of chronic disease is expected to increase, particularly conditions such as hypertension and diabetes. As more residents live with multiple complex conditions, managing chronic disease may become increasingly challenging if community-based resources are not scaled to meet growing demand.

2. IMPROVING PRIMARY CARE ACCESS

Access to primary care is a concern at all levels of government. In Niagara, the higher ratio of patients per physician suggests that Niagara residents are more likely to wait longer to access their primary care provider. Addressing the unattached population is important, as improved access to primary care can support prevention, continuity of care, and help alleviate pressures on hospitals.

3. UNDERSTANDING MENTAL HEALTH AND SUBSTANCE USE

Mental health and substance use are closely interconnected. Limited access to mental health support can result in substance use or substance use can exacerbate mental health. Opioid use continues to be a persistent concern. Current data supports that those who visit the Emergency Department (ED) for mental health concerns are more likely to lack basic essential resources such as education, income and basic housing. The Canadian Mental Health Association reports that services required in Niagara are steadily increasing each year.

4. COMMUNICABLE DISEASE AND OUTBREAK PREPAREDNESS

The re-emergence of vaccine preventable diseases such as Pertussis and Measles stresses the importance of vaccinations, surveillance and public health response capacity. Communicable diseases can be acquired and transmitted quickly within a short time, requiring timely prevention measures and well-developed outbreak management practices to support effective response when needed.

5. ADDRESSING HEALTH EQUITY AND ACCESS TO CARE

Health and wellness go beyond having the right staff and resources in place. It also requires making changes at the systems-level that address barriers and discrimination that can impede access to care. This involves addressing language, geographical, income and educational barriers, as well as discrimination to equity-deserving groups, including the Indigenous population. Addressing these barriers is important to support equitable access and improve health outcomes across the region.

6. EMERGENCY MEDICAL SERVICES PRESSURES

An increasing and aging population suggests that the health care system will require more resources. This includes Emergency Medical Services, as current and forecasted data suggest demand will increase, indicating a plan is needed in place to adapt to these changing patterns. This includes addressing staffing and other resource requirements at the operational level to adapt to changing patterns and achieve response time goals.

7. HOSPITAL SYSTEM PRESSURES

Hospitals are fundamental pillars of the health system, requiring substantial resources to operate effectively. Recent trends indicate increasing acute inpatient cases, rising cumulative length of stay, and ongoing bed pressures. These patterns point to the need for strategies that support patient flow, reduce avoidable admissions and optimize capacity.

8. INCREASING DEMAND FOR LONG-TERM AND HOSPICE CARE

As Niagara's population ages, the demand for long-term care and hospice services will continue to increase. The current number of applications for long-term care beds and the limited availability of hospice beds suggest that access challenges may intensify if capacity is not expanded.

9. UNDERSTANDING HOMELESSNESS AND SUPPORTIVE HOUSING

Housing is one of many factors that can determine an individual's health and impact how people utilize the health system. Shelter usage in Niagara is consistently high, reflecting ongoing need. Supportive housing warrants further attention, as it addresses underlying social and environmental factors, supports long-term housing stability, and can reduce reliance on emergency and acute care services.

ADDRESSING THE GAPS

Local health teams are uniquely positioned to help bridge gaps within the health system by fostering collaboration, enhancing service integration, and tailoring solutions to meet local needs. Through coordinated efforts across primary care, hospitals, public health, social services, and community organizations, local partners can work together to improve access to care, reduce fragmentation, and support more equitable health outcomes.

By leveraging local data, engaging system partners, and implementing coordinated care approaches, the NOHT-ÉSON can play an important role in addressing unmet needs and supporting populations who face barriers to care.

The following areas are presented for consideration by NOHT-ÉSON as potential priorities for coordinated system-level planning. These recommendations are informed by the findings of this assessment and aligned with both the CIHI Stuff–Space–Staff–Systems framework and the NOHT-ÉSON 2024–27 Strategic Plan. Some of the recommendations may need further tailoring for different organizations within the system.

Health System Capacity Gap	Short- and Medium-Term Recommendations	Long-Term Recommendations
1. Increasing Chronic Disease Burden **NOHT/ÉSON PILLAR:** System Integration	1.1 Explore opportunities to expand community-based chronic disease management programs (e.g. COPD, heart failure, diabetes) 1.2 Implement frailty and risk stratification tools in primary care and home care to identify patients at risk of hospitalization 1.3 Develop region-wide seniors' integrated care pathways (such as Primary Care + Home Care + Specialists) for chronic conditions such as hypertension and cardiovascular disease 1.4 Scale clinics and interdisciplinary models for complex chronic disease management for older adults	1.5 Integrate predictive analytics to support proactive identification and case management of high-risk patients across primary care, home care and hospital settings.
2. Primary Care Access and Unattached Patients **NOHT/ÉSON PILLAR:** Primary Care	2.1 Continue and enhance communication to Niagara residents on the availability of Primary Care System Navigators and self-serve resources for finding a doctor. Evaluate the single front door model for navigation to ensure clients reach services ("right time, first time"). 2.2 Explore bolstering opportunities to expand attachment models using Nurse Practitioners and team-based primary care 2.3 Design for speed, not solely attachment. Determine appropriate daily targets for same day/ next day and virtual/phone appointments 2.4 Incentivize practice in areas with high patient-to-physician ratios such as Fort Erie, Wainfleet and Niagara Falls 2.5 Consider mobile primary care units for rural/ underserved communities 2.6 Amplify support for Indigenous-led primary care capacity within Aboriginal Health Centres as well as other Indigenous roles in healthcare delivery	2.7 Develop a succession plan for aging physicians and other primary care providers to mitigate retirement-related gaps 2.8 Consider strengthening primary care access through expanded use of electronic referral (eReferral) systems and improved access to shared digital patient records to support smoother navigation, coordination across providers, and timely access to care for unattached patients.

Health System Capacity Gap	Short- and Medium-Term Recommendations	Long-Term Recommendations
3. Mental Health and Substance Use **NOHT/ÉSON PILLARS:** Safety and Inclusivity & Primary Care	3.1 Increase naloxone distribution and harm-reduction access (RAAM) capacity 3.3 Expand Indigenous-led land-based healing and culturally grounded detox and recovery supports 3.4 Explore evidence-based prevention programs tailored to youth and young adults to increase education, skill building and addressing anti-stigma in relation to substance use 3.5 Participate and/or support Niagara's Substance Use Strategy, where appropriate	
4. Communicable Disease Preparedness **NOHT/ÉSON PILLAR:** System Integration	4.1 Strengthen outbreak response protocols and partner communication pathways across Public health, hospitals, Long-Term Care (LTC), primary care and community agencies 4.2 Expand vaccination outreach (mobile, multilingual, Indigenous led) 4.3 Enhance region-wide communicable disease surveillance reporting and data sharing 4.4 Review and assess workflows and workloads related to communicable disease management to find efficiencies and prioritize high-impact activities	

Health System Capacity Gap	Short- and Medium-Term Recommendations	Long-Term Recommendations
5. Health Equity and Access **NOHT/ÉSON PILLARS:** Indigenous Health & Safety and Inclusivity	5.1 Embed the Health Equity Assessment Tool and apply best practices into decision-making for all system initiatives 5.2 Expand mobile care and outreach for rural, low-income, and Indigenous communities 5.3 Invest in Indigenous, Francophone, and newcomer navigation services to support culturally and linguistically appropriate care.	5.4 Strengthen sociodemographic data collection and integration across sectors. While available data allow for analysis by geography and area-level deprivation (ON-Marg), person-level sociodemographic information is not yet consistently collected across the health system. Addressing this gap through a coordinated, standardized approach should be a key priority in future phases of planning.
6. EMS Pressures **NOHT/ÉSON PILLAR:** System Integration	6.1 Determine how the Niagara EMS's Mobile Integrated Health (MIH) model supports seniors and chronic disease patients and identify what supports are needed to scale or optimize it 6.2 Identify factors and develop methods to improve recruitment, retention and workforce resilience. 6.3 Leverage EMS data to identify high-risk patients and connect them to preventive and community-based programs 6.4 Advance the 10-year EMS Master Facilities Plan and determine any supports that may be required	

Health System Capacity Gap	Short- and Medium-Term Recommendations	Long-Term Recommendations
7. Hospital Pressures **NOHT/ÉSON PILLAR:** System Integration	7.1 Leverage hospital utilization data to prioritize system planning for high-volume conditions and populations in partnership with primary care, community and social service providers to strengthen upstream and transitional supports 7.2 Continue to collaborate on EMS–hospital offload delays to identify system-level opportunities to improve 7.3 Continue to explore integrated care pathways for frequent patients/high-risk patients	7.4 Address ALC pressures by increasing and aligning post-acute capacity across home and community care, long-term care, hospice and supportive housing, ensuring patients no longer requiring hospital-level care have timely access to appropriate alternatives 7.5 Coordinate hospital capacity planning with community, LTC, hospice and supportive housing strategies to improve system flow in the future
8. Understanding Homelessness and Supportive Housing **NOHT/ÉSON PILLAR:** System Integration	8.1 Review Niagara's Supportive Housing Strategy and determine how the NOHT-ÉSON can assist with implementation and alignment with health system goals 8.2 Explore tactics to bolster the reach of Niagara's HART Hub to increase access to supportive housing while also increasing access to addictions and mental health treatment.	8.3 Create more housing that better meets community needs, including highly supportive housing for individuals with complex health and mental-health needs
9. Increasing Demand for LTC and Hospice care **NOHT/ÉSON PILLARS:** System Integration & Workforce	9.1 Advocate for increased LTC home bed capacity in municipalities with larger wait lists such as St. Catharines, Welland and Niagara Falls and in alignment with demographic projections and ALC trends 9.2 Increase hospice bed capacity based on population forecasting	9.3 Develop long-term forecasting for LTC and hospice demand

Health System Capacity Gap	Short- and Medium-Term Recommendations	Long-Term Recommendations
10. Workforce Planning and Sustainability **NOHT/ÉSON PILLARS:** Workforce & Trust and Accountability	10.1 Leverage data-driven forecasting to anticipate staffing needs based on patient volumes, acuity levels and demographic trends. Incorporate historical data and seasonal fluctuations to optimize staffing models, with flexibility in mind. 10.2 Build capacity amongst partners on the use of Integrated Decision Support (IDS) data sharing platform for detailed and timely data on population health monitoring and performance management. 10.3 Support upskilling for emerging roles – Train staff for digital health, virtual care and AI-enabled roles to meet evolving delivery models 10.4 Technology integration – Use AI powered documentation processes to reduce administrative burden and improve clinician satisfaction 10.5 Local talent – work with Brock University and Niagara College to fund training programs for nurse and allied health professionals and create career pathways for sustainability 10.6 Diversity and Inclusion – tailor strategies for multigenerational workforce engagement and create gender equity initiatives	10.7 Work toward a coordinated, multi-sector health human resources data set to support regional workforce planning and accountability

CLOSING CALL TO ACTION

Improving health outcomes across Niagara requires more than identifying system pressures; it requires coordinated, evidence-informed action across sectors. This assessment provides a shared baseline of population health trends, service utilization, and capacity constraints to support collective planning by the Niagara Ontario Health Team–Équipe Santé Ontario Niagara (NOHT-ÉSON) and system partners.

The findings and recommendations outlined in this report are intended to inform priority setting, align planning efforts, and support integration across the continuum of care. Addressing the identified gaps will require collaboration among hospitals, primary care, public health, community organizations, social services, municipalities, and Indigenous partners, with a continued focus on equity, access, and sustainability.

To support this work, an engagement approach has been developed to enable partners to use this assessment as a foundation for shared discussion and coordinated planning. This report is intended to support ongoing system-level assessment and priority setting, recognizing that health system capacity must continue to be monitored and adapted over time as population needs, service demands, and system pressures evolve.

ADDITIONAL DATA RESOURCES

THE NIAGARA WELL-BEING TOOL

This interactive tool provides data for Niagara's 12 municipalities and 44 neighbourhoods. It allows the user to explore information about the community in the areas of demographics, education and employment, housing and income.
Niagara Well-Being Tool - Niagara Region, Ontario

NIAGARA PRIORITY PROFILES

The profiles provide information about specific populations in Niagara.
Niagara Priority Profiles - Niagara Region, Ontario

PUBLIC HEALTH ONTARIO SNAPSHOTS

According to Public Health Ontario: Snapshots are a collection of interactive map-based dashboards showing both geographic and temporal trends for key public health indicators by public health unit (PHU) and Ontario overall. Select Snapshots include other sub-provincial geographies where available. All Snapshots provide dynamically linked tables, graphs, and maps with pre-calculated statistics.
Chronic Disease Mortality Snapshot | Public Health Ontario

PUBLIC HEALTH ONTARIO MARGINALIZATION INDEX TOOL

Ontario Marginalization Index (ON-Marg) | Public Health Ontario

ONTARIO HEALTH CANCER PROFILES

Ontario Cancer Profiles | Cancer Care Ontario

PROJECTED PATTERNS OF ILLNESS IN ONTARIO

Projection of chronic diseases into 2040

APPENDIX B:
ADDITIONAL SUMMARIES AND DATA

SUPPLEMENTARY INFORMATION ON DEMOGRAPHICS

Population Estimates[21] for Niagara by Per Cent Change in Population Size

	2023	2024	Per cent Change (2023 to 2024)
Niagara	524,301	539,180	^ 2.8
West Lincoln	16,785	16,702	v 0.5
Wainfleet	7,459	7,444	v 0.2
Niagara-on-the-Lake	20,249	20,254	^ 0.0
Lincoln	28,527	28,634	^ 0.4
Pelham	19,679	19,855	^ 0.9
Fort Erie	36,334	36,945	^ 1.7
Port Colborne	21,459	21,830	^ 1.7
Grimsby	30,964	31,578	^ 2.0
St. Catharines	149,903	152,958	^ 2.0
Thorold	26,485	27,313	^ 3.1
Welland	61,176	63,874	^ 4.4
Niagara Falls	105,281	111,793	^ 6.2

Data Source:
Statistics Canada Population estimates, July 1, by census subdivision, 2021 boundaries, 2025

[21] The Census of Population and Statistics Canada's population estimates both aim to measure the number of people living in Canada, but they do so in distinct ways. The Census is a nationwide survey conducted every five years, providing a detailed snapshot of demographics such as age, income, and housing at a specific point in time. In contrast, population estimates are updated more frequently—every quarter and year—using the latest census data along with vital statistics like births, deaths, and migration records. While the Census offers comprehensive baseline data, population estimates keep the picture current and dynamic. Together, they complement each other to support planning, policy, and research.

VISIBLE MINORITY

	Niagara		Ontario		Difference Compared to Ontario
	Number of People	Per cent of Population	Number of People	Per cent of Population	
South Asian	13,845	22.2%	1,515,295	31.5%	⌄ 9.3%
Black	13,305	21.3%	768,740	16.0%	⌃ 5.4%
Latin American	6,975	11.2%	249,190	5.2%	⌃ 6.0%
Chinese	6,675	10.7%	820,245	17.0%	⌄ 6.3%
Filipino	6,505	10.4%	363,650	7.5%	⌃ 2.9%
Arab	3,580	5.7%	284,215	5.9%	⌄ 0.2%
Southeast Asian	3,210	5.1%	167,845	3.5%	⌃ 1.7%
Multiple visible minorities	3,050	4.9%	181,025	3.8%	⌃ 1.1%
Korean	1,920	3.1%	99,425	2.1%	⌃ 1.0%
Visible minority not listed	1,525	2.4%	124,120	2.6%	⌄ 0.1%
West Asian	1,030	1.7%	212,185	4.4%	⌄ 2.8%
Japanese	770	1.2%	31,420	0.7%	⌃ 0.6%

Data Source:
Statistics Canada Census, 2021

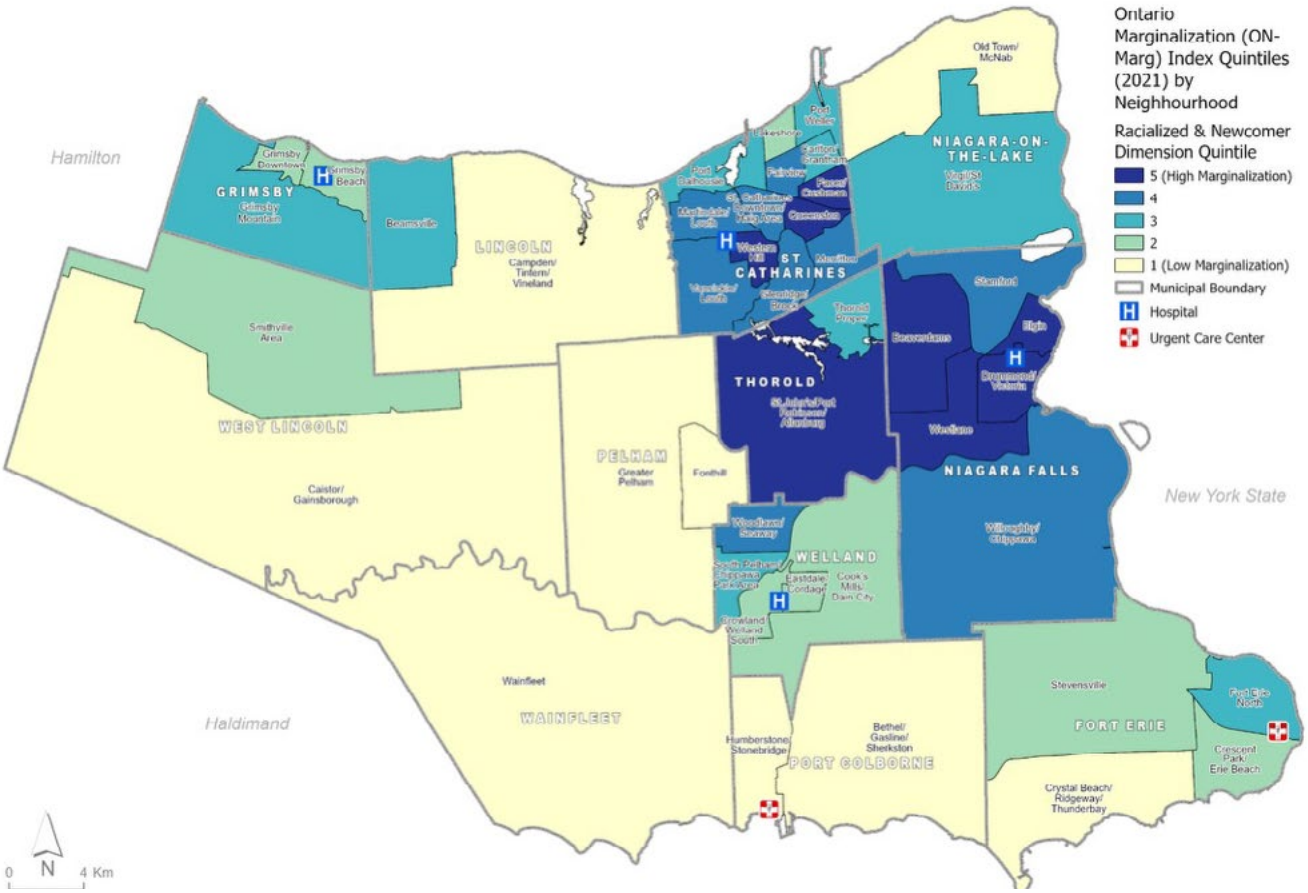
INTERNATIONAL STUDENT POPULATION

	Brock University		Niagara College	
	Number of People	Per cent of Student Population	Number of People	Per cent of Student Population
2018-2019	1,854	11.3%	3,968	37.2%
2019-2020	2,197	12.9%	3,714	36.7%
2020-2021	2,143	12.7%	2,486	29.5%
2021-2022	2,051	12.3%	3,688	40.5%
2022-2023	2,055	12.3%	9,077	63.7%
2023-2024	1,968	11.8%	13,891	72.5%

Data Source:
Ontario Data Catalogue, 2025

Note:
International students are defined as those with student permit/Student visa: a permit obtained by a student to enter Canada for the sole purpose of attending an educational postsecondary institution. Dates are based on headcount starting in the fall term and does not account for those who withdraw during the time period.

Niagara College consistently has higher percentage of international students compared to Brock University. In 2023-24, Brock University reported 1,968 or 11.8 per cent of their student body as international students. The 5-year average from 2018-19 to 2022-23 is 12.3 per cent. In 2023-24, Niagara College reported 13,891 or 72.5 per cent of their student body as international students. The 5-year average from 2018-19 to 2022-23 is 43.6 per cent.


Ontario Marginalization (ON-Marg) Index Quintiles (2021) by Neighhourhood
Racialized & Newcomer Dimension Quintile
5 (High Marginalization)
4
3
2
1 (Low Marginalization)
Municipal Boundary
Hospital
Urgent Care Center
Hamilton
Haldimand
New York State
GRIMSBY
LINCOLN
WEST LINCOLN
PELHAM
THOROLD
WELLAND
NIAGARA FALLS
NIAGARA-ON-THE-LAKE
WAINFLEET
PORT COLBORNE
FORT ERIE
ST CATHARINES
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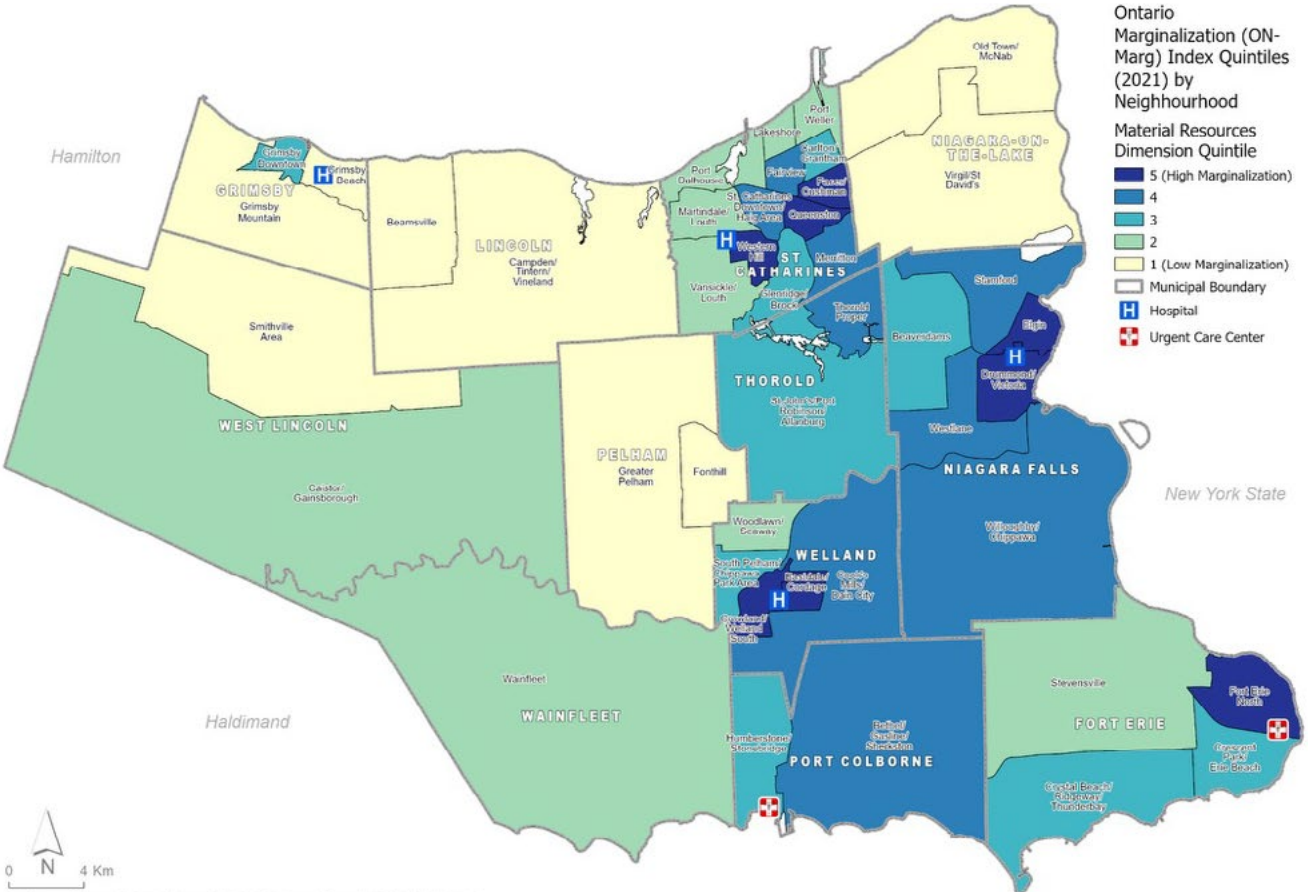

Ontario Marginalization (ON-Marg) Index Quintiles (2021) by Neighhourhood
Material Resources Dimension Quintile
5 (High Marginalization)
4
3
2
1 (Low Marginalization)
Municipal Boundary
Hospital
Urgent Care Center
Hamilton
Haldimand
New York State
GRIMSBY
LINCOLN
WEST LINCOLN
PELHAM
THOROLD
WELLAND
NIAGARA FALLS
NIAGARA-ON-THE-LAKE
WAINFLEET
PORT COLBORNE
FORT ERIE
ST CATHARINES
0 N 4 Km

SUPPLEMENTARY INFORMATION ON POPULATION HEALTH

EARLY DEVELOPMENT

The first five years of a child's life are most important and are the foundation that shapes children's health, social-emotional well-being, growth, development and learning achievements at school, in the family and in the community. The Early Development Instrument is a tool that measures the developmental health and well-being of children and determines whether children are meeting the appropriate expectations that are typical of five-year-olds. In Niagara, children are most at-risk in the physical health and well-being domain (gross and fine motor skills, physical independence, and physical readiness for the school day) as 19.1 per cent are reported to be vulnerable. However, children are at less risk in the language and cognitive development domain (literacy skills, numeracy skills and interest in math, reading and memory) as 7.3 per cent are reported to be vulnerable.[22]

NIAGARA CHILDREN WHO HAVE ACTIVE TOOTH DECAY

Healthy teeth, even at a very early age, are an essential part of overall health. Oral health can affect the functional, psychological and social dimensions of a child's well-being and oral pain can have devastating effects on children, including lost sleep, poor growth and learning, and behavioural problems. In Niagara, dental screenings are conducted each year for students in junior kindergarten and all the way to grade 8. However, screening is only required in JK/SK and grades 2, 4 and 7. Kindergarten and grade 2 students are among the most vulnerable groups for tooth decay, with active decay rates of 13.1 per cent and 11.9 per cent, respectively, compared to 4.9 per cent in Grade 7.[23]

[22]Early Development Instrument, 2024
[23]Oral Health Information Support System (OHISS, 2024)

SEXUALLY TRANSMITTED INFECTIONS (STIS)

Data Source:
Integrated Public Health Information System (iPHIS)

Note:
A case of a communicable disease is defined as a confirmed and/or probable instance of a Disease of Public Health Significance as designated under the Health Protection and Promotion Act (HPPA).

WHAT ARE THE MOST COMMON STIS IN NIAGARA?

Chlamydia is the most common occurring sexually transmitted infection with 1,305 cases in 2024. This is followed by gonorrhea (322 cases), syphilis (199 cases), Hepatitis C (128 cases) and HIV/AIDS (67 cases)

Chlamydia cases are reported mostly among females and between the ages 20-29. The most reported risk factors for Chlamydia include: No contraceptive (condom) was used, multiple sexual contacts in the last six months and sexual intercourse with the same sex.

Case trends in the last five years show three noticeable trends:

- Increase in Syphilis cases since 2019
- Increase in HIV cases since 2023
- Decrease in Hepatitis C cases 2022

In comparison, Chlamydia and Gonorrhea trends are more stable

Rates are similar for Niagara and Ontario, with Niagara being slightly lower than Ontario.

SO WHAT?

Sexually transmitted infections (STIs) remain a persistent public health concern, with rising incidence rates across multiple age groups and genders. Infections such as chlamydia, gonorrhea, and syphilis are of particular concern, as limited access to sexual health services, stigma, and gaps in education contribute to underdiagnosis and delays in treatment, increasing both transmission risk and long-term health complications. Monitoring STI patterns is essential for health system capacity planning, as shifting trends can signal increased demand for testing, treatment, and interventions. Without this knowledge, the system risks gaps in care, higher downstream costs, and greater strain, underscoring the need for innovative and alternative resources to respond effectively.

VECTORBORNE DISEASES

According to the World Health Organization, "vector-borne diseases are human illnesses caused by parasites, viruses, and bacteria that are transmitted by vectors."[24] Vectors (living organisms) transmit pathogens from animals to humans or between humans. Mosquitoes and Ticks are common vectors causing many different vector-borne diseases, including West Nile Virus illnesses and Lyme Disease. A warmer climate will lead to the intensification of both diseases, among others and trends show that the overall rates of diseases are increasing but are consistently lower when compared to Ontario.

In 2024, there were 33 cases of Lyme Disease and four cases of West Nile Virus Illness.[25] Cases are reported mostly among males across all age groups. The most reported risk factors for Lyme disease include engaging in activities in wooded or tall grass areas, not having adequate clothing protection in wooded or tall grass areas and not using insect repellent in wooded or tall grass areas.

[24] World Health Organization. (2024). Vector-borne diseases. Retrieved from Vector-borne diseases (who.int).

[25] Integrated Public Health Information System (iPHIS), 2025

SO WHAT?

Understanding vector borne disease patterns is critical for health system planning because climate change can increase transmission risk, leading to sudden surges in demand for diagnostics, treatment and interventions. These insights enable proactive resource allocation, surveillance and prevention strategies to avoid system strain. Without this knowledge, planning risks delayed response and higher healthcare burden.

FOOD AND WATERBORNE DISEASES

Enteric and foodborne illnesses are often linked to contaminated food, water or poor hygiene practices. Common pathogens such as Salmonella, Campylobacter enteritis and Norovirus contribute to significant morbidity particularly among young children, older adults and immuno-compromised individuals. While public health measures and food safety regulations reduce the overall burden of disease, challenges remain in the timely detection, reporting and response to these illnesses. Of note, it is important to recognize that many of these illnesses can also be caused by travel-related exposures and are not necessarily attributed to local health risks such as climate change.

WHAT FOOD AND WATERBORNE DISEASES ARE COMMON IN NIAGARA?

Campylobacter Enteritis is the most common enteric disease with 109 cases in 2024. Cases are reported mostly among males and those age 40 years and older. The most reported risk factors for Campylobacter Enteritis include consumption of chicken/chicken products, consumption of egg/egg products and consumption of raw fruits. Other common food and waterborne diseases include Salmonellosis (85 cases), Cryptosporidiosis (33 cases), Giardiasis (26 cases) and cyclosporiasis (16 cases).[26]

Over the last five years, there are two noticeable trends: an increase in Salmonella cases since 2021 and an increase in Cryptosporidiosis cases in 2024. Rates of these diseases are generally trending upward to pre-pandemic levels and remain slightly lower in Niagara compared to Ontario.

[26] Integrated Public Health Information System (iPHIS), 2025

2023 PUBLIC HEALTH ANALYSIS OF TOP 25 HEALTH CONDITIONS AND DISEASES IN NIAGARA

The table below presents the analysis completed by Niagara Region Public Health to identify top health conditions and diseases in Niagara in 2023. The assessment ranks health conditions and diseases by both quantitative and qualitative criteria, resulting in a list of conditions ranked from highest to lowest burden in Niagara.

Quantitative Criteria include number of deaths, potential years of life lost (PYLL), ED visits, hospitalizations and length of stay. Qualitative criteria include community acceptance of emphasis on condition, opportunities to make an impact, and availability of interventions to address issue. Data were tabulated for ranking the health conditions and diseases using the nationally acceptable framework developed by the Winnipeg Regional Health Authority.[27]

[27] Harlos, Sande. Setting Injury Priorities. SMARTRISK Learning Series. Winnipeg Regional Health Authority. (2007).

[28] Becker, Roberto, Silvi, John, Ma Fat, Doris, L'Hours, André & Laurenti, Ruy.). A method for deriving leading causes of death. Bulletin of the World Health Organization, 84. (2006).

Overall Ranking	Health Condition or Disease using Becker Category[1]	Quantitative Rank	Qualitative Rank	Total Combined Rank	Difference in Rank (2023 vs. 2019) + = greater burden in 2023
1	Ischaemic heart disease	2	5	7	**0.0**
2	Accidental falls	1	8.5	9.5	**0.0**
3	Chronic lower respiratory diseases	5	8.5	13.5	**+3.0**
4	Diabetes	10	5	15	**-1.0**
5	Cerebrovascular disease	4	12.5	16.5	**-0.5**
6.5	Perinatal conditions	9	8.5	17.5	**+2.0**
6.5	COVID-19	6.5	11	17.5	**-**
8	Accidental poisoning	16	2	18	**+3.0**
9	Cirrhosis and other liver diseases	17.5	2	19.5	**-0.5**
10	Lung, bronchus, and trachea cancer	13.5	8.5	22	**-5.5**
11	Influenza and pneumonia	11	12.5	23.5	**-4.0**
12	Intentional self-harm	22	2	24	**-2.0**
13	Diseases of the urinary system	3	22.5	25.5	**-1.0**
14	Heart failure	8	19	27	**+1.0**
15	Diseases of the musculoskeletal system and connective tissue	6.5	22.5	29	**+1.0**
16	Sexually transmitted infections	25	5	30	**+1.0**
17	Dementia and Alzheimer disease	15	16.5	31.5	**+3.0**
18	Pregnancy, childbirth and the puerperium	13.5	18	31.5	**0.0**

Overall Ranking	Health Condition or Disease using Becker Category[1]	Quantitative Rank	Qualitative Rank	Total Combined Rank	Difference in Rank (2023 vs. 2019) + = greater burden in 2023
19	Colon, rectum, and anus cancer	17.5	16.5	34	**-6.0**
20	Transport accidents	20	14.5	34.5	**-1.0**
21	Appendicitis, hernia, and intestinal obstruction	12	24	36	**+2.0**
22	Breast cancer	24	14.5	38.5	**-1.0**
23	Lymph, blood, and related cancers	21	21	42	**-1.0**
24	Acute respiratory diseases	23	20	43	**+1.0**
25	Septicaemia	19	25	44	**+1.0**

SUPPLEMENTARY INFORMATION ON SYSTEM RESOURCES AND HEALTHCARE UTILIZATION

Data Source:
Ontario, 2025

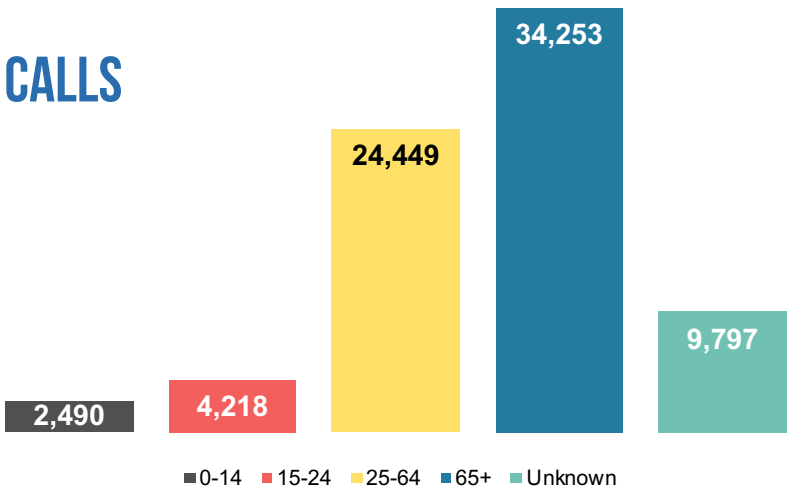
Note:
Data are current as of July 31, 2025; Individuals can list up to three homes on their application

Number of Long-Term Care Homes by Municipality with Bed Count and Waiting List Applications

	Number of Long-Term Care Homes	Total	Number of People
Fort Erie	3	324	246
Grimsby	2	184	526
Lincoln	2	360	623
Niagara Falls	6	760	832
Niagara-on-the-Lake	2	165	222
Port Colborne	1	151	245
St. Catharines	9	1,296	2,482
Welland	5	581	978
Total	**30**	**3,821**	**6,154**

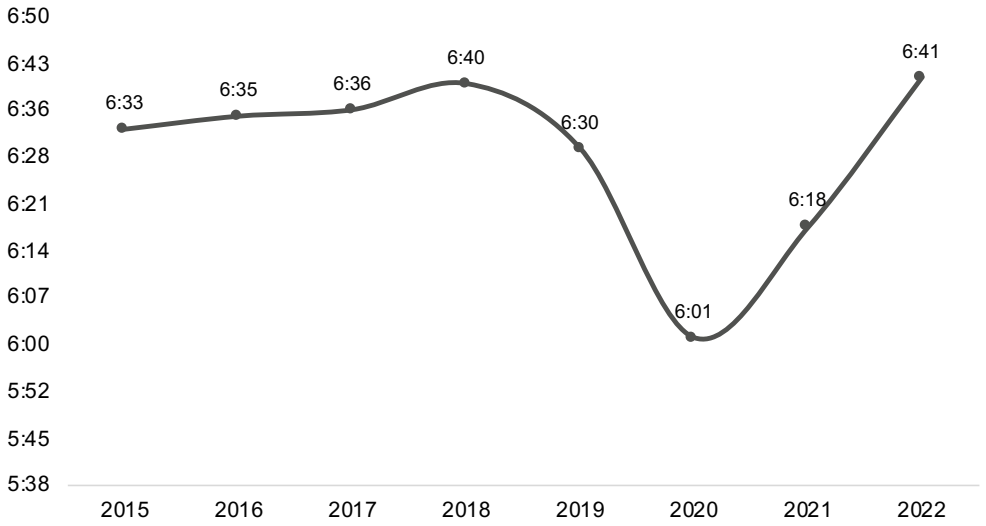
PATIENT AGE AT TIME OF CONTACT FOR EMS CALLS

Data Source:
Niagara Emergency Medical Services, 2025



AVERAGE EMS RESPONSE TIMES OVER TIME FOR NIAGARA

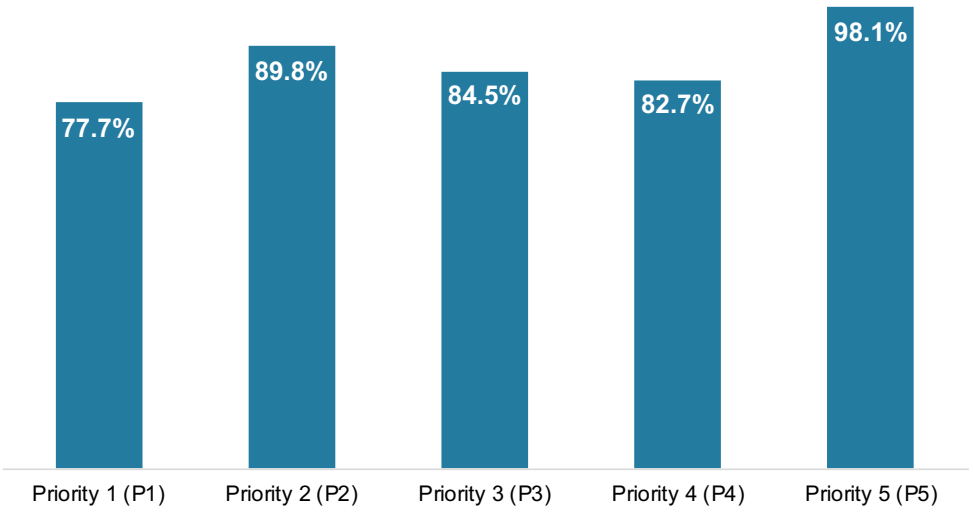
Data Source:
Ontario, 2025



Note:
Average response times are the average time from when an ambulance is assigned in response to a call to when it arrives on scene. Response times can vary and vary for different reasons; differences in geography, population growth, number of ambulances being utilized and offload times are some examples.

PERCENTAGE OF RESPONDED EMS CALLS WITHIN TARGET TIME

Data Source:
Niagara Emergency Medical Services, 2022



Note:
For P1 and P2 incidents, response times are measured from the time the vehicle is notified to the time the vehicle arrives at the scene for the first vehicle arriving at the scene. For P3 to P5 incidents, response times are measured from the time the call is answered. Utilization is defined as the proportion of a vehicle's planned shift time that is spent responding and dealing with patient care (measured from time of mobilization to posting clear). This excludes time spent on rest breaks, returning to base, and administrative work. Response time targets are based on historical response times and are approved by Niagara Regional Council.

PERCENTAGE OF P1 EMS RESPONSES THAT MEET TARGET RESPONSE TIME SCENARIOS

Municipality	2023 Baseline Re-sponse %	2033 (Do Nothing Model)	2033 (Increase Staff/ Fleet Model)	2033 (Hub, Spoke and Post Facilities Model)
Fort Erie	73.4%	58.6%	79.3%	75.5%
Grimsby	58.4%	44.8%	83.1%	78.3%
Lincoln	46.0%	44.5%	70.1%	75.9%
Niagara Falls	81.5%	74.5%	86.4%	91.9%
Niagara-on-the-Lake	51.8%	49.5%	80.5%	80.9%
Pelham	72.1%	56.6%	77.4%	80.8%
Port Colborne	82.1%	63.5%	86.7%	88.9%
St Catharines	86.6%	81.7%	90.1%	93.8%
Thorold	68.6%	55.7%	71.1%	77.3%
Wainfleet	28.7%	23.5%	37.4%	39.0%
Welland	93.7%	88.8%	94.0%	96.9%
West Lincoln	49.1%	39.0%	67.0%	68.7%
Overall	**78.9%**	**70.8%**	**84.7%**	**88.1%**

Data Source:
Operational Research in Health Limited, 2024; Niagara Emergency Medical Services, 2024

Based on current data, four municipalities are meeting their 80% targets, while the region overall is not. If changes or enhancements are not made, results will continue to decline, where only two municipalities meet targets by 2033.

Under two slightly different models where investments are made to staff, fleet size and EMS sites; forecasts indicate that more municipalities, including the region overall, will improve the percentage of response times for P1 calls that meet the 80 per cent target

HOMELESS SHELTER USAGE

Year	Number of times services used (intake)	Number of unique clients	Per cent of shelter exits that don't return in 180 days	Average length of stay
2021	2,520	1,246	37.1	28.1
2022	2,570	1,312	27.0	33.7
2023	3,696	1,646	25.7	27.6
2024	4,994	1,914	27.4	23.1
2025	4,118	1,560	22.6	22.9

Data Source:
Niagara Region, 2025

SUPPLEMENTARY INFORMATION ON WORKFORCE PLANNING

NATIONAL OCCUPATION CATEGORIES USED IN WORKFORCE PLANNING

NOC	Description
30010	Managers in health care
31100	Specialists in clinical and laboratory medicine
31101	Specialists in surgery
31102	General practitioners and family physicians
31110	Dentists
31112	Audiologists and speech-language pathologists
31120	Pharmacists
31121	Dietitians and nutritionists
31200	Psychologists
31202	Physiotherapists
31203	Occupational therapists
31204	Kinesiologists and other professional occupations in therapy and assessment
31300	Nursing coordinators and supervisors
31301	Registered nurses and registered psychiatric nurses
31302	Nurse practitioners

NOC	Description
31303	Physician assistants, midwives and allied health professionals
32101	Licensed practical nurses
32102	Paramedical occupations
32103	Respiratory therapists, clinical perfusionists and cardiopulmo-nary technologists
32109	Other technical occupations in therapy and assessment
32111	Dental hygienists and dental therapists
32112	Dental technologists and technicians
32120	Medical laboratory technologists
32121	Medical radiation technologists
32122	Medical sonographers
32123	Cardiology technologists and electrophysiological diagnostic technologists
32124	Pharmacy technicians
32129	Other medical technologists and technicians
32201	Massage therapists
33100	Dental assistants and dental laboratory assistants
33101	Medical laboratory assistants and related technical occupations
33102	Nurse aides, orderlies and patient service associates
33103	Pharmacy technical assistants and pharmacy assistants
2024	4,994